

Lessons from Personhood's Defeat: Abortion Restrictions and Side Effects on Women's Health

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State personhood laws pose a puzzle. These laws would establish fertilized eggs as persons and, by doing so, would ban all abortions. Many states have consistently supported laws restricting abortion care. Yet, thus far no personhood laws have passed. Why? This Article offers a possible explanation and draws lessons from that explanation for understanding and resisting abortion restrictions more broadly. I suggest that voters' recognition of the implications of personhood legislation for health issues other than abortion may have led to personhood's defeat. In other words, opponents of personhood proposals appear to have successfully reconnected abortion to pregnancy care, contraception, fertility, and women's health in general. Public concern over the "side effects" of personhood laws seems to have persuaded even those opposed to abortion to reject personhood legislation. If this is so, personhood opponents may have struck on a strategy that could apply more broadly. As this Article explains, various anti-abortion regulations—not just personhood laws—have deleterious "side effects" on women's health. Focusing the public's attention on these side effects could not only create stronger support for access to abortion care but could also better promote the full spectrum of women's healthcare needs.

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I. INTRODUCTION

Over the last several decades, as part of the movement against abortion rights, abortion has become increasingly stigmatized and isolated in women's health.¹ The current segregation of abortion from the rest of women's medical needs brings us full circle back to questions raised by *Roe v. Wade*.² Although *Roe* was rightly criticized as over-medicalizing the abortion decision and empowering doctors rather than women, we have now shifted to the opposite extreme of severing abortion completely from the realm of women's health.³ A number of scholars have argued for reconnecting abortion with women's health and framing abortion care as an aspect of healthcare.⁴ This Article sits within that line of scholarship urging a connection between abortion and healthcare, but does so through the unique lens of personhood legislation.

¹ See Lori Freedman, Uta Landy, Philip Darney & Jody Steinauer, *Obstacles to the Integration of Abortion into Obstetrics and Gynecology Practice*, 42 PERSP. ON SEXUAL & REPROD. HEALTH 146, 146 (2010) ("Since legalization, abortion services have increasingly become consolidated into the socially insulated settings of specialized abortion clinics. These clinics, which provide 93% of abortions, are largely segregated from other medical settings Many members of the reproductive rights community have advocated for integrating abortion into full-spectrum obstetrics and gynecology and primary care settings, to take the burden off the clinics and to normalize abortion as a standard component of reproductive health care." (footnote omitted)).

² *Roe v. Wade*, 410 U.S. 113 (1973).

³ See *infra* Part V (discussing criticisms of *Roe* and disassociation of abortion care from women's healthcare).

⁴ See *infra* Part V (discussing scholarship arguing for a greater understanding of abortion as a key component of women's healthcare).

Recently, a series of ballot initiatives and legislative proposals, primarily at the state level, have sought to declare that legally protectable human life begins at the moment of fertilization. "Personhood" laws would ban all abortions, which is their primary aim. Strikingly, despite a recent surge in support for severe restrictions on abortion, thus far no personhood laws have passed. The uniform failure in the push for zygote personhood appears to lie in reproductive rights advocates' success in linking personhood proposals to health issues other than abortion. Personhood legislation's likely "side effects" are wide ranging, including limits on women's access to a broad range of healthcare and infringements on women's right to liberty and equality in numerous contexts. Ironically, the personhood movement's attempt to vilify abortion by personifying the fetus may serve as an opportunity to educate the public about the importance of preserving access to abortion care in order to preserve access to less stigmatized forms of healthcare.

This Article examines the recent movement to establish fertilized eggs as legal persons (the movement for "personhood" legislation) and seeks to draw lessons from the defeat of those laws for resisting abortion restrictions more broadly. It argues that voters' recognition of the implications of personhood legislation for health issues other than abortion likely led to personhood's defeat. In other words, opponents of personhood proposals seem to have successfully reconnected abortion to pregnancy care, contraception, fertility, and women's health in general. Public concern over the "side effects" of personhood laws seems to have persuaded even those opposed to abortion to reject personhood legislation. If this is so, personhood opponents may have struck on a line of reasoning that could apply more broadly. As this Article explains, various anti-abortion regulations—not just personhood laws—have deleterious "side effects" on women's health. Focusing the public's attention on the side effects of abortion restrictions on women's healthcare could help to build a greater understanding of the links between abortion care and women's health. Uncovering these links could create stronger support for access to abortion and thereby better promote full healthcare access for women.

In Part II, I summarize the history of the recent movement to establish personhood for fertilized eggs. Personhood USA, a group that has been a leader in the current charge for personhood, has helped to push numerous ballot initiatives and legislative proposals at the state level, articulating its key goal as putting an end to abortion. Federal proposals for personhood have also surfaced, but neither federal nor state initiatives have yet met with any success. The personhood movement's nationwide failure is remarkable given the climate of hostility to abortion rights in many states. This Part also contrasts the failures of personhood proposals with the success of ever more invasive abortion restrictions, such as biased "informed consent" laws, forced ultrasounds, bans on later abortion, and burdensome regulations designed to shut down abortion clinics.

In Part III, I survey the wide range of implications if a personhood law were successfully passed and upheld by the courts. Personhood legislation would ban

all abortion care, including in cases of rape and incest. In addition, these laws would limit access to other types of healthcare as well as impinge upon women's right to liberty and equality in areas ranging from criminal law to family law and employment law. Part III also argues that these implications, particularly on women's healthcare choices other than abortion, appear to be a key reason for the overwhelming failure of the current personhood movement, despite the extreme hostility to abortion rights across many states.

In Part IV, I demonstrate that, as a matter of medical reality, abortion cannot be isolated from the continuum of women's healthcare. Thus far, the public appears to have recognized this reality in the context of personhood legislation, but has otherwise failed to understand the interconnectedness of abortion with women's health generally. In fact, existing anti-abortion laws and policies already impinge upon women's healthcare outside the abortion context, but these effects remain obscured. Part IV examines how current abortion restrictions harm women's health even for women not actively seeking abortion care. In particular, existing restrictions targeted at abortion have spillover effects on miscarriage management, prenatal care, and the treatment of ectopic pregnancies.

Finally, in Part V, I suggest that the battles over personhood legislation provide an example to learn from and an opportunity for public education. In particular, focusing the public's attention on the deleterious consequences for women's health of various anti-abortion laws—not just personhood laws—could help make visible the links between abortion and healthcare. I also note that, as other scholars have argued, framing abortion as a healthcare issue offers a potentially useful strategy for increasing support for access to abortion care.

Abortion cannot be segregated from women's healthcare more broadly. We can see this by unmasking the "side effects" of abortion restrictions such as personhood proposals and other existing anti-abortion policies. It appears likely that the public has rejected personhood legislation because these laws would impede the provision of basic healthcare other than abortion. Other types of anti-abortion laws have "side effects" on women's health similar to personhood laws, but the public has failed to discern these impacts. Educating the public about the full healthcare consequences of abortion restrictions could be one key means to preserving access to abortion care. Repositioning the law to recognize access to abortion care as part of the continuum of women's medical needs is critical to protecting women's health.

II. A BRIEF HISTORY OF THE PERSONHOOD MOVEMENT

Although the "personhood movement" has garnered much attention in recent years, its history goes back at least to *Roe v. Wade*. Following *Roe*, anti-abortion groups sought to amend the Constitution to declare that life begins at

conception.⁵ Anti-abortion advocates introduced many versions of a Human Life Amendment in Congress, but none succeeded.⁶

After years of an incremental approach to restricting access to abortion care, the movement to establish legal personhood at the moment of conception has recently revived. Since 2008, numerous personhood initiatives have sprung up throughout the United States. While the language and form of these proposals vary from state to state (legislative bills in some states versus ballot initiatives voted on directly by the public in others), each essentially attempts to secure legal rights for pre-born human beings starting from the moment of fertilization or conception.⁷ Personhood USA, a religious, pro-life group, and its president and founder Keith Mason, are active leaders of the personhood movement.⁸ Throughout the nation, Personhood USA has helped spark the introduction of ballot initiatives and personhood bills in fifteen states.⁹ The movement is also supported by proposed federal legislation.¹⁰

A. State Ballot Initiatives

The Personhood USA coalition group has launched numerous ballot initiatives in fifteen different states for the purpose of adding personhood amendments to state constitutions.¹¹ These amendments attempt to legally

⁵ See MARY ZIEGLER, *ROE'S ROAD NOT TAKEN: THE LOST HISTORY OF THE ABORTION DEBATE, 1973–1983* (forthcoming); Mary Ziegler, *Ways to Change: A Reevaluation of Article V Campaigns and Legislative Constitutionalism*, 2009 BYU L. REV. 969, 970 n.5 (discussing history of human-life amendments).

⁶ Glen A. Halva-Neubauer & Sara L. Zeigler, *Promoting Fetal Personhood: The Rhetorical and Legislative Strategies of the Pro-Life Movement After Planned Parenthood v. Casey*, 22 FEMINIST FORMATIONS 101, 102–03 (2010).

⁷ The Personhood USA website defines the movement as follows: “Personhood is a movement working to respect the God-given right to life by recognizing all human beings as persons who are ‘created in the image of God’ from the beginning of their biological development, without exceptions.” *About Us*, PERSONHOOD USA, <http://www.personhoodusa.com/about?source=button> (last visited Dec. 14, 2012).

⁸ See generally PERSONHOOD USA, <http://www.personhoodusa.com/> (last visited Jan. 13, 2013) (discussing Personhood USA and its objectives).

⁹ Alabama, Arkansas, California, Colorado, Florida, Kansas, Montana, Nevada, New Hampshire, Ohio, Oklahoma, Oregon, Virginia, Washington, and Wisconsin. See *Personhood Bills and Ballot Initiatives*, RESOLVE: THE NAT'L INFERTILITY ASS'N, <http://www.resolve.org/get-involved/personhood-bills-and-ballot-initiatives.html> (last visited Jan. 13, 2013) (listing states and the status of their legislative initiatives).

¹⁰ See generally Sanctity of Human Life Act, H.R. 212, 112th Cong. (2011). See also H.R. 212 (112th): *Sanctity of Human Life Act*, GOVTRACK.US, <http://www.govtrack.us/congress/bills/112/hr212> (last visited Jan. 13, 2013) (providing the proposed Act's history and an overview).

¹¹ Alabama, Arkansas, Mississippi, Oklahoma, Ohio, Nevada, California, Colorado, Oregon, Montana, Florida, Kansas, New Hampshire, Virginia, Washington, and Wisconsin. See *Personhood Bills and Ballot Initiatives*, *supra* note 9 (listing states and ballot initiative progress); see also *Get Involved*, PERSONHOOD USA, <http://www.personhoodusa.com/map>

define human embryos as people with legal rights from the moment of fertilization. Voters have opposed these personhood measures, which have proved overwhelmingly unsuccessful both in the past and in their more recent incarnations.¹² This lack of success has held even in Personhood USA's home state of Colorado, where in 2008 and 2010 Colorado voters shut down personhood initiatives.¹³ Despite previous voter opposition, Mason was vocal about his nationwide push for states to add personhood amendments to their 2012 ballots.¹⁴ The ability for states to do so has clearly been a challenge.¹⁵

As of June 2012, the only active states collecting signatures for personhood initiatives to appear on November 2012 ballots were Colorado, Montana, Ohio, and Oregon.¹⁶ Initiative efforts in Montana and Ohio failed by wide margins, while initiative backers in Oregon chose not to submit any signatures for tallying due to low numbers.¹⁷ Colorado was the only state in the nation able to gather enough signatures that if valid would have placed the personhood

(last visited February 14, 2013) (for current status of personhood movements in individual states).

¹² Abigail Pesta, *'Personhood' Movement Stumbles in Colorado Ballot Initiative*, DAILY BEAST (Aug. 29, 2012, 7:03 PM), <http://www.thedailybeast.com/articles/2012/08/29/pro-life-personhood-movements-hits-snap-in-colorado-ballot-initiative.html>.

¹³ In 2008, 73% of voters rejected the personhood measure, and again in 2010, 71% of voters did the same. Peter Marcus, *Personhood Proposal Disqualified from Ballot*, COLO. STATESMAN, Aug. 31, 2012, at 5.

¹⁴ Abigail Pesta, *War of the Wombs: Keith Mason's Campaign for Embryo Rights*, DAILY BEAST (June 25, 2012, 1:00 AM), <http://www.thedailybeast.com/newsweek/2012/06/24/personhood-usa-s-keith-mason-eyes-election-day-2012.html>.

¹⁵ Ballot initiatives failed to make ballots in Nevada, Ohio, and Florida. Personhood Florida failed to collect enough signatures for its amendment to appear on the 2012 ballot. Only about 20,000 signatures were collected—a total far short of the 676,811 signatures needed. Personhood Florida will try again for the 2014 ballot. Tara Culp-Ressler, *Radical Personhood Initiatives Fail in States Across the Country*, THINKPROGRESS (July 5, 2012, 2:15 PM), <http://thinkprogress.org/health/2012/07/05/511421/radical-personhood-initiatives-fail-in-states-across-the-country/>; see *Florida*, PARENTS AGAINST PERSONHOOD, <http://parentsagainstpersonhood.com/legislation/florida/> (last visited Dec. 16, 2012) (discussing Personhood Florida's proposed amendment).

¹⁶ Efforts to gather sufficient signatures in California and Nevada failed as well. *Initial Efforts Fail in NV, CA, and OK*, PARENTS AGAINST PERSONHOOD (June 19, 2012), <http://parentsagainstpersonhood.com/category/legislation/california/>.

¹⁷ Personhood Ohio only gathered about 30,000 of the 385,000 signatures needed. Culp-Ressler, *supra* note 15. Montana gathered only 23,512 signatures of 48,674 needed. Charles Johnson, *Marijuana, Abortion Measures Won't Be on Ballot*, INDEP. REC. (Helena), July 21, 2012, at A9, available at http://helenair.com/news/local/govt-and-politics/marijuana-legalization-anti-abortion-personhood-measures-fail-to-make-ballot/article_1cabe85c-d2f1-11e1-a312-001a4bcf887a.html. Oregon Personhood initiative required 116,283 signatures to appear on the November ballot. However, no signatures were submitted to the Secretary of State for consideration. *Oregon*, PARENTS AGAINST PERSONHOOD, <http://parentsagainstpersonhood.com/legislation/oregon/> (last visited Dec. 16, 2012).

measure on the November 2012 ballot.¹⁸ After the Secretary of State's examination of the signatures, however, it was determined that the number of valid signatures fell short of the amount required for the initiative to make the ballot.¹⁹ Personhood Colorado had thirty days to challenge the decision and expressed its intent to file an appeal.²⁰ As of September 2012, the nation's only pending personhood ballot measure was in Colorado and appeared unlikely to reach voters. Thus, not a single personhood initiative seemed likely to make the 2012 ballots.

In addition to voter rejection of personhood measures and lack of ballot-initiative support, state courts have struck down personhood legislation.²¹ Despite this opposition, the movement to define a fertilized egg as a human with legal rights continues, as Personhood USA has expressed it will push for ballot initiatives in 2014.²²

On October 29, 2012, the Supreme Court declined, without providing reason, to review an abortion-related appeal regarding the Oklahoma Supreme Court's holding that Initiative Petition 395 is unconstitutional.²³ Initiative Petition 395 is a proposed ballot measure that would amend Oklahoma's state constitution to define fertilized human eggs as persons with legal rights.²⁴

B. State Legislative Proposals

In 2011, a number of state legislatures introduced various personhood measures, although none of them were passed into law.²⁵ For example, in

¹⁸ Electa Draper, *Signatures Turned in for Colorado Anti-Abortion Measure*, DENVERPOST.COM (Aug. 6, 2012, 7:38 PM), http://www.denverpost.com/breakingnews/ci_21249998/personhood-coalition-turns-signatures-ballot-measure.

¹⁹ A total of 106,119 signatures were submitted to the Secretary of State in support of Colorado's Personhood initiative. 86,105 signatures were required to make the fall ballot. However, state officials found that only 82,246 signatures were valid. The Secretary of State's disqualification of the initiative made it unlikely that the personhood initiative would make the November ballot. Electa Draper & Lynn Bartels, *Colorado Anti-Abortion Initiative Misses Ballot, Backers Hire Lawyer*, DENVERPOST.COM (Aug. 29, 2012, 5:47 PM), http://www.denverpost.com/breakingnews/ci_21426365/colorado-anti-abortion-initiative-misses-ballot-by-3; see Pesta, *supra* note 12 (discussing the Colorado Secretary of State's finding and Personhood USA's plans to fight it in court).

²⁰ Marcus, *supra* note 13.

²¹ Nevada and Oklahoma courts have struck down proposed personhood measures. *Personhood Nevada v. Bristol*, 245 P.3d 572, 576 (Nev. 2010); *In re Initiative Petition No. 395*, State Question No. 761, 286 P.3d 637, 637 (Okla. 2012).

²² Pesta, *supra* note 14.

²³ Bill Mears, *Supreme Court Rejects Abortion-Related Appeal*, CNN (Oct. 29, 2012, 10:09 AM), http://www.cnn.com/2012/10/29/justice/court-abortion/index.html?hpt=ju_c2.

²⁴ Initiative Petition No. 395, State Question No. 761 (Okla. 2012), available at <http://www.sos.ok.gov/documents/questions/761.pdf>.

²⁵ Pesta, *supra* note 14. In 2011, North Dakota, Iowa, Kansas, Texas, Georgia, and Montana all introduced personhood legislation. Rebecca Millette, *Personhood Bills*

February 2011, the North Dakota House passed The Defense of Human Life Act, which defines a human being as “an individual member of the species homo sapiens at every stage of development,”²⁶ but the bill failed to pass the Senate.²⁷

In 2012, “eleven states—more than in any previous year—have introduced personhood bills”²⁸ However every single piece of proposed legislation failed to pass into law.²⁹ Virginia and Oklahoma are two states that illustrate the difficulty personhood legislation faces today. Lawmakers passed recent personhood bills in Virginia in the House of Delegates, and in Oklahoma through the Senate,³⁰ however both bills failed to become law.³¹ The Virginia Senate declined to vote on the personhood bill by sending it back to committee,³² and the Oklahoma House failed to bring the Senate-passed personhood legislation to a vote.³³ Thus, both effectively “killed” the bills for the 2012 session. Other personhood bills were stalled at committee and remained undecided.³⁴

C. Federal Legislative Proposals

Federal personhood legislation has also been recently proposed. In 2011, Vice-Presidential nominee Paul Ryan co-sponsored H.R. 212, the Sanctity of Human Life Act, which declares, “[T]he life of each human being begins with fertilization”³⁵ Currently, however, there is no federal legislation in place

Introduced, Gain Traction Across U.S., LIFESITENEWS.COM (Feb. 15, 2011, 4:29 PM), <http://www.lifesitenews.com/news/personhood-bills-introduced-gain-traction-across-us/>.

²⁶ H.B. 1450, 62d Leg. Assem., at 3 (N.D. 2011), available at <http://www.legis.nd.gov/assembly/62-2011/documents/11-0665-02000.pdf>.

²⁷ A similar personhood bill failed to pass the senate in 2009. H.B. 1572, 61st Leg. Assem. (N.D. 2009), available at <http://www.legis.nd.gov/assembly/61-2009/bill-text/JRDS0200.pdf>.

²⁸ Lee Rubin Collins & Susan L. Crokin, *Fighting ‘Personhood’ Initiatives in the United States*, 24 REPROD. BIOMED. ONLINE 689, 690 (2012).

²⁹ Personhood legislation failed to pass in the 2012 state legislature sessions of Alabama, Iowa, Kansas, Mississippi, Oklahoma, South Carolina, Virginia, and Wisconsin. See *Legislation*, PARENTS AGAINST PERSONHOOD, <http://parentsagainstopersonhood.com/legislation/> (last visited Feb. 14, 2013) (describing personhood legislation throughout the nation).

³⁰ Aliyah Shahid, *‘Personhood’ Bills Being Pushed in U.S. as Abortion, Social Issues Come to Fore in GOP Presidential Contest*, NYDAILYNEWS.COM (Feb. 21, 2012), http://articles.nydailynews.com/2012-02-16/news/31069300_1_personhood-usa-abortion-gay-marriage.

³¹ Culp-Ressler, *supra* note 15.

³² *Id.* The Virginia Senate voted to allow the bill to carry over to the next term, where its sponsor may offer it for additional consideration. *Id.*

³³ *Id.*

³⁴ Bills in Alabama and Iowa are stalled at committee. *Id.*

³⁵ The proposed statute states, “[T]he life of each human being begins with fertilization, cloning, or its functional equivalent, irrespective of sex, health, function or disability, defect,

that operates to determine the legal status of embryos, but a personhood statute like the Sanctity of Human Life Act, if enacted, could regulate to this effect.³⁶

D. *The Rise of Restrictive Abortion Regulations*

The failure of personhood proposals contrasts sharply with the success of ever more invasive abortion restrictions in recent years. For example, in 2011, state legislators introduced more than 1,100 reproductive health-related provisions, and fully 68% of those new provisions restricted access to abortion services (up from 26% in 2010).³⁷ This flurry of anti-abortion sentiment resulted in ninety-two new abortion restrictions enacted into law, shattering the previous record high of thirty-four abortion restrictions adopted in 2005.³⁸ In the past several years, both state and federal legislation have reduced access to abortion care using a wide variety of regulatory methods, including: reducing funding for abortion services; banning types of abortion procedures; controlling information surrounding abortion care; banning later abortions; and imposing burdensome regulations targeted solely at abortion providers and abortion facilities.³⁹ Below, I discuss a few examples of popular abortion restrictions to illustrate the contrast with the failure of personhood laws in the same recent time period.

One key method of regulating abortion has been controlling information surrounding abortion care. So-called “informed consent” laws, which are in fact biased laws aimed at discouraging abortion, have proliferated since the Supreme Court’s 2007 decision in *Gonzales v. Carhart*.⁴⁰ As of today, sixteen states mandate misinformation for women seeking abortion care—such as that abortion has lasting negative mental health consequences—although that claim

stage of biological development, or condition of dependency, at which time every human being shall have all the legal and constitutional attributes and privileges of personhood” Sanctity of Human Life Act, H.R. 212, 112th Cong. § 2(1)(B) (2011).

³⁶ Nadia Kounang, *Could ‘Personhood’ Bills Outlaw IVF?*, CNN.COM (Aug. 30, 2012, 5:00 PM), <http://www.cnn.com/2012/08/30/health/ivf-outlawed/index.html>.

³⁷ *Laws Affecting Reproductive Health and Rights: 2011 State Policy Review*, GUTTMACHER INST., <http://www.guttmacher.org/statecenter/updates/2011/statetrends42011.html> (last visited Feb. 14, 2013).

³⁸ See *id.*

³⁹ See Rachel Rebouché & Karen H. Rothenberg, *Mixed Messages: The Intersection of Prenatal Genetic Testing and Abortion*, 55 HOW. L.J. 983, 998–1005 (2011) (summarizing sharp increases in abortion restrictions at the federal and state levels in recent years and noting that legislation currently pending foretell additional restrictions); Halva-Neubauer & Zeigler, *supra* note 6, at 118 (analyzing myriad incremental measures restricting access to abortion care and concluding that the data shows “growing pro-life success”).

⁴⁰ *Gonzales v. Carhart*, 550 U.S. 124 (2007); see Maya Manian, *The Irrational Woman: Informed Consent and Abortion Decision-Making*, 16 DUKE J. GENDER L. & POL’Y 223, 244–45 (2009) (demonstrating how abortion-specific “informed consent” legislation deviates from standard principles of informed consent for other medical care).

has been proven untrue.⁴¹ As part of these “informed consent” laws, twenty-six states mandate a twenty-four to forty-eight hour waiting period, and ten of these states require that the biased “counseling be provided in person,” which requires the woman to make two separate trips to the clinic.⁴² For example, South Dakota, which has only one abortion clinic in the entire state, enacted legislation requiring women to be told—falsely—that abortion could increase their risk of suicide and then face a seventy-two hour waiting period prior to receiving abortion care.⁴³ Mandatory ultrasound laws further illustrate the extremes to which states have gone to control what information abortion patients must be given prior to receiving abortion care.⁴⁴ Three states have passed laws forcing women seeking to terminate their pregnancies to undergo ultrasounds regardless of whether the physician would typically provide an ultrasound, and to hear the fetus’s heartbeat and descriptions of the sonogram “even if women ask not to see the images.”⁴⁵

Another trend in recent years has been the prohibition on pre-viability abortions at twenty weeks based on the theory that fetuses can feel pain at that point, although that theory is disputed by mainstream medical organizations.⁴⁶ As of June 2011, six states passed twenty-week bans with exceptions only for the pregnant woman’s life or in cases of serious physical impairment of the

⁴¹ *State Policies in Brief: Counseling and Waiting Periods for Abortion*, GUTTMACHER INST. (Feb. 1, 2013), available at http://www.guttmacher.org/statecenter/spibs/spib_MWPA.pdf [hereinafter *Counseling and Waiting Periods for Abortion*]; see Heather D. Boonstra, *Comprehensive Evidence Review Concludes Abortion Does Not Harm Women’s Mental Health*, 11 GUTTMACHER POL’Y REV. 4 (2008), available at <http://www.guttmacher.org/pubs/gpr/11/4/gpr110420.html> (discounting the claim that abortion has a negative effect on women’s mental health); see also AM. PSYCHOLOGICAL ASS’N TASK FORCE REPORT ON MENTAL HEALTH & ABORTION, REPORT OF THE TASK FORCE ON MENTAL HEALTH AND ABORTION 92 (2008), available at <http://www.apa.org/pi/women/programs/abortion/mental-health.pdf>.

⁴² *Counseling and Waiting Periods for Abortion*, *supra* note 41.

⁴³ See *Planned Parenthood Minn., N.D., S.D. v. Rounds*, 686 F.3d 889, 906 (8th Cir. 2012) (holding that suicide advisory laws were not unconstitutional); Maya Manian, *Perverting Informed Consent: The South Dakota Court Decision*, RH REALITY CHECK (Aug. 1, 2012, 10:08 PM), <http://www.rhrealitycheck.org/article/2012/08/01/perverting-informed-consent-south-dakota>.

⁴⁴ Nine states require that patients be given the opportunity to view an ultrasound image if the provider would conduct an ultrasound, and “six states mandate that physicians give all patients opportunities to view ultrasound images regardless of whether the physician would typically conduct an ultrasound.” Rebouché & Rothenberg, *supra* note 39, at 1015; see *Laws Affecting Reproductive Health and Rights: 2012 State Policy Review*, GUTTMACHER INST., <http://www.guttmacher.org/statecenter/updates/2012/statetrends42012.html> (last visited Feb. 14, 2013) [hereinafter *Laws Affecting Reproductive Health and Rights: 2012 State Policy Review*]; see also Carol Sanger, *Seeing and Believing: Mandatory Ultrasound and the Path to a Protected Choice*, 56 UCLA L. REV. 351, 376 (2008).

⁴⁵ Rebouché & Rothenberg, *supra* note 39, at 1015–16 (describing mandatory ultrasound laws enacted in North Carolina, Oklahoma, and Texas).

⁴⁶ I. Glenn Cohen & Sadeth Sayeed, *Fetal Pain, Abortion, Viability, and the Constitution*, 39 J.L. MED. & ETHICS 235, 238–39 (2011).

woman's "bodily function."⁴⁷ Generally, these bans have no exemption for other physical health risks, mental health, rape and incest, or fetal anomaly. In defending these twenty-week bans on abortion with no health exception for fetal anomalies, one Georgia state legislator compared women to farm animals stating that, like pigs and cows, women should be forced to carry nonviable fetuses to term.⁴⁸ In Nebraska, which has such a twenty-week ban in effect, one woman went public with her story of the impact of this type of law. Thirty-four-year-old Danielle Deaver described how, at twenty-two weeks, her water broke prematurely.⁴⁹ She learned that her fetus would not be able to develop lungs and would die at birth.⁵⁰ But because of Nebraska's new law, Deaver's doctor could not perform an abortion.⁵¹ Instead, she had to wait to give birth, then watch for fifteen agonizing minutes as her underdeveloped baby gasped for breath and died.⁵²

Finally, targeted regulation of abortion providers (TRAP legislation) has also been a method of restricting access to abortion care. State laws regulating abortion facilities and providers vary, and include requirements such as admitting privileges at hospitals, regulations of facility design, ambulatory surgical requirements, and detailed record keeping.⁵³ These burdensome regulations often go beyond what is medically necessary for abortion providers and, in some cases, are designed to shut down abortion clinics. Mississippi recently passed a law that illustrates the impact of TRAP legislation.

⁴⁷ *State Policies in Brief: State Policies on Later Abortion*, GUTTMACHER INST. (Mar. 21, 2013), http://www.guttmacher.org/statecenter/spibs/spib_PLTA.pdf. A few of these twenty-week bans have recently been challenged in court. See Emily Bazelon, *Why Arizona's 20-Week Abortion Ban Is Unconstitutional*, SLATE (Nov. 5, 2012, 4:52 PM), http://www.slate.com/articles/news_and_politics/politics/2012/11/arizona_s_20_week_abortion_ban_is_unconstitutional.html (discussing challenge to Arizona law which bans abortions after twenty weeks); *Ga. Judge Grants Injunction Against 20-Week Abortion Ban*, NAT'L PARTNERSHIP FOR WOMEN & FAMILIES (Jan. 3, 2013), http://www.nationalpartnership.org/site/News2?page=NewsArticle&id=37269&security=3161&news_iv_ctrl=3164 (discussing challenge to Georgia's H.B. 954, which bans twenty-week abortions without "exceptions for rape or incest, most cases of severe fetal anomaly or danger to a woman's health").

⁴⁸ See Leigh Owens, *Terry England, Georgia Republican Lawmaker, Compares Women to Farm Animals*, HUFFINGTON POST (Mar. 9, 2012, 6:32 PM), http://www.huffingtonpost.com/2012/03/09/terry-england-farm-animals_n_1335976.html.

⁴⁹ *Id.*

⁵⁰ *Id.*

⁵¹ *Id.*

⁵² See *Abortion Law: Mother Denied Abortion, Then Had to Watch Baby Die*, NEBRASKASTATEPAPER.COM (Mar. 7, 2011), <http://nebraska.statepaper.com/vnews/display.v/ART/2011/03/07/4d746bd70eb25>.

⁵³ See *Laws Affecting Reproductive Health and Rights: 2012 State Policy Review*, *supra* note 44 (detailing TRAP regulations enacted in Arizona, Michigan, and Virginia); Rebouché & Rothenberg, *supra* note 39, at 1002–03 (describing TRAP regulations); Gillian E. Metzger, *Abortion, Equality, and Administrative Regulation*, 56 EMORY L.J. 865, 873–75 (2007) (discussing TRAP laws).

Mississippi has some of the country's strictest abortion laws and only one remaining abortion clinic.⁵⁴ In 2012, state legislators put into effect a law requiring "all abortion providers to be board certified in obstetrics and gynecology and have admitting privileges at a local hospital."⁵⁵ The lone clinic's providers are already board-certified ob-gyns, but local hospitals denied privileges to the two physicians who provide the majority of procedures "after a months-long effort by the clinic to obtain them."⁵⁶ Although claiming the law serves to protect women's health, some advocates of the law have openly expressed the goal of shutting down the last abortion clinic and making Mississippi an abortion free state.⁵⁷ Yet, even Mississippi—shockingly—failed to pass a personhood ballot initiative.⁵⁸

The personhood movement's failure in Mississippi and nationwide is remarkable given this climate of hostility to abortion rights in many states during the same time period. The uniform failure in the push for zygote personhood appears rooted, at least in part, in reproductive rights advocates' success in linking personhood proposals to health issues other than abortion for which the public has much more sympathy. These other implications of personhood legislation are examined further below.

III. THE SIDE EFFECTS OF PERSONHOOD LEGISLATION

Since U.S. law has never granted legal personhood from the moment of fertilization, the full implications of personhood legislation remain uncertain. In this Part, I show several of the likely implications for women's access to healthcare and rights to liberty and equality in healthcare decision-making under a personhood regime. I also argue that the likely reason for the failure of personhood proposals even in states extremely hostile to abortion rights lies in this link between personhood legislation and healthcare.

A. *The Implications of Treating Zygotes as Legal Persons*

The potential effects of personhood laws are wide ranging, from restrictions on women's healthcare to bans on stem cell research. This section briefly

⁵⁴ See *State Facts About Abortion: Mississippi*, GUTTMACHER INST., <http://www.guttmacher.org/pubs/sfaa/mississippi.html> (last visited Jan. 20, 2013).

⁵⁵ Emily Le Coz, *Mississippi's Last Abortion Clinic Faces Closure*, CHI. TRIB. (Nov. 28, 2012), <http://www.chicagotribune.com/health/sns-rt-us-usa-abortion-mississippibre8ar18v-20121128,0,6829531.story>.

⁵⁶ *Id.*

⁵⁷ See Rich Phillips, *Law Could Force Mississippi's Only Abortion Clinic to Close*, CNN.COM (June 30, 2012, 6:50 PM), <http://www.cnn.com/2012/06/30/us/mississippi-abortion-clinic/index.html> (noting that when Gov. Phil Bryant signed the bill, he stated it was a step towards ending abortion in Mississippi).

⁵⁸ See Denise Grady, *Medical Nuances Drove 'No' Vote in Mississippi*, N.Y. TIMES, Nov. 15, 2011, at D1.

summarizes likely implications for access to abortion, pregnancy care, contraception, fertility treatments, and broader implications for the legal regulation of women's behavior during pregnancy. Proponents of personhood legislation claim that discussion of these implications amounts to "fear mongering."⁵⁹ Keith Mason and other leaders of the personhood movement deliberately obfuscate the full spectrum of a personhood law's impacts, claiming that such a law would only ban abortion.⁶⁰ Although the complete extent of a personhood law's likely impact remains uncertain, evidence of the effects of personhood-type laws in other countries and analysis by many scholars and commentators suggest that concerns about the "side effects" of personhood laws are valid.⁶¹

1. *Abortion and Pregnancy Care*

In 1973, the United States Supreme Court issued its landmark decision in *Roe v. Wade* granting women a constitutional right to seek abortion care.⁶² In *Planned Parenthood of Southeastern Pennsylvania v. Casey*, the Court reaffirmed a woman's constitutional right to choose to have an abortion, but rejected *Roe*'s trimester framework and adopted the much less stringent "undue burden" test.⁶³ Under *Casey*, a woman has a right to choose to have an abortion before viability, but the State has legitimate interests in both the health of the mother and the life of the fetus from the moment of conception.⁶⁴ In *Roe*, the Supreme Court held that the word "person" in the Constitution "does not include the unborn," and thus constitutional rights only apply postnatally.⁶⁵ Personhood activists have seized on this language and seek to redefine "person" to include the unborn from the moment of fertilization. There is no question that personhood laws are a direct attempt to ban abortion and deny women the right to reproductive choice established in *Roe* and *Casey*.⁶⁶

⁵⁹ Jonathan F. Will, *Measure 26. Fear Mongering, Self-Execution & Potential Implications for Birth Control*, 81 MISS. L.J. SUPRA 63, 64 (2011), <http://mississippilawjournal.org/wp-content/uploads/2012/04/Supra-81-Prop-26-Symposium-Essay-Will.pdf>.

⁶⁰ See Abigail Pesta, *War of the Wombs: The Battle for 'Personhood' Heats Up*, NEWSWEEK, July 9, 2012, at 20–21 (describing Mason's statement that he is not against contraception or fertility treatments, but admits that personhood laws would alter IVF procedures and ban IUDs and emergency contraception which he views as abortifacients); Julie Rovner, *Abortion Foes Push to Redefine Personhood*, NPR (June 1, 2011, 3:23 PM), <http://www.npr.org/2011/06/01/136850622/abortion-foes-push-to-redefine-personhood> (describing Mason's view regarding the effect of personhood legislation on abortion and birth control).

⁶¹ See *infra* Part III.A.1–4.

⁶² *Roe v. Wade*, 410 U.S. 113, 155 (1973).

⁶³ *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 876 (1992).

⁶⁴ *Id.* at 876–77.

⁶⁵ *Roe*, 410 U.S. at 157–58.

⁶⁶ For example, federal personhood legislation, known as The Sanctity of Human Life Act, H.R. 212, if passed and upheld by the Supreme Court, would give Congress the power,

Under a personhood regime, all abortions could be banned including in cases of rape and incest. Abortions would be a crime, since a fertilized egg would be a citizen with legal rights, and the loss of that citizen's right to life would constitute murder.⁶⁷ Traditionally, the common law did not consider abortion a crime because a live birth had not yet occurred.⁶⁸ As legislatures developed criminal abortion statutes, they specifically provided for protections for the unborn without penalizing the pregnant woman or holding her criminally liable as an offender or accomplice.⁶⁹ However, by statutory change in the definition of the word "person," personhood laws may have the effect of subjecting women to criminal prosecution and liability for the harm or death of her embryos.⁷⁰

It remains unclear whether abortion would be permitted in a situation where a pregnancy threatened a woman's life or health. Personhood laws would make physicians liable for providing abortion care and "could make any effort to terminate a pregnancy a criminal act, [and] it could also bar doctors from saving the lives of women with ectopic pregnancies, which are never viable and need to be terminated as soon as possible."⁷¹ Personhood laws may also limit the

and states the authority, to ban all abortions. See H.R. 212, 112th Cong. (2011); see also, e.g., Press Release, Personhood Ohio, Alabama Supreme Court Ruling Changes Pro-Life Landscape (Apr. 18, 2012), available at <http://personhoodohio.com/press-release/alabama-supreme-court-ruling-changes-pro-life-landscape> (discussing the aim of personhood laws, and the personhood movement, to overturn *Roe v. Wade* and ban abortion).

⁶⁷ Valena Beety, *Mississippi Initiative 26: Personhood and the Criminalization of Intentional and Unintentional Acts by Pregnant Women*, 81 MISS. L.J. SUPRA 55, 55–58 (2011), available at <http://mississippilawjournal.org/wp-content/uploads/2012/04/Supra-81-Prop-26-Symposium-Essay-Beety.pdf>.

⁶⁸ *Id.* at 57 (citing *Roe*, 410 U.S. at 161–62, which described how U.S. law had only accorded legal rights to unborn children in inheritance and tort law, and then only when a pregnancy resulted in a live birth were unborn children deemed to have recognized legal rights).

⁶⁹ See, e.g., MISS. CODE ANN. § 41-41-45(4) (West Supp. 2012) ("Any person, except the pregnant woman, who purposefully, knowingly or recklessly performs or attempts to perform or induce an abortion in the State of Mississippi, except in the case where necessary for the preservation of the mother's life or where the pregnancy was caused by rape, upon conviction, shall be punished by imprisonment in the custody of the Department of Corrections for not less than one (1) year nor more than ten (10) years."); see also *Roe*, 410 U.S. at 158 n.54 (commenting that abortion statutes typically did not hold the mother liable as a principal or accomplice to the abortion performed upon her).

⁷⁰ See, e.g., Beety, *supra* note 67, at 57–58 (commenting on the effect that Mississippi's Personhood Initiative 26 could have on criminal liability and prosecutions of mothers for harm to or death of a fetus by abortion).

⁷¹ Marie Diamond, *Anti-Abortion Groups Push to Outlaw Contraceptives by Redefining Personhood*, THINKPROGRESS (June 3, 2011, 2:40 PM), <http://thinkprogress.org/justice/2011/06/03/235552/personhood-bills-attack-contraception/>; see also L. Lewis Wall & Douglas Brown, *Regarding Zygotes as Persons: Implications for Public Policy*, 49 PERSP. BIOLOGY & MED. 602, 606–09 (2006) (noting that 75% of human conceptions die spontaneously before reaching viability and that recognizing zygote personhood would change the definition of pregnancy and dramatically alter the healthcare system).

ability of physicians to provide care for pregnant women with cancer, as a recent incident from the Dominican Republic illustrates. In 2010, the Dominican Republic adopted a new constitution recognizing personhood from the moment of conception.⁷² This law led to tragic consequences for “Esperanza,” a sixteen-year-old pregnant girl who died in August 2012 from complications due to acute leukemia. Esperanza needed chemotherapy, but the doctors refused to provide the treatment due to fear of prosecution for causing the death of the fetus. By the time the government intervened and ordered chemotherapy be provided, it was too late—the cancer had progressed and Esperanza eventually died.⁷³

2. Contraception

According to the Guttmacher Institute, every year in the United States sixty-two million women are of childbearing age, of which 62% use contraception.⁷⁴ Contraception has many benefits, both for pregnancy and non-pregnancy purposes.⁷⁵ Attempts to ban contraception are not new, and anti-contraception legislation was common prior to the Supreme Court's decision in *Griswold v. Connecticut*. In 1965, *Griswold* held that a Connecticut law forbidding the use of contraceptives violated the right to privacy protected by the Due Process Clause for married couples.⁷⁶ In 1972, in *Eisenstadt v. Baird*, the Supreme Court extended protection of the right to access contraceptives to unmarried persons.⁷⁷

In addition to banning abortion, personhood laws could also give government the authority to prohibit some of the most effective methods of

⁷² CONSTITUCIÓN POLÍTICA DE LA REPÚBLICA DOMINICANA (2010) art. 37 (Dom. Rep.).

⁷³ The girl's name was withheld by the hospital in order to protect her identity, but the local press has referred to her as Esperanza. See Rafael Romo, *Pregnant Dominican Teen at Center of Abortion Debate Dies*, CNN.COM (Aug. 17, 2012), http://articles.cnn.com/2012-08-17/americas/world_americas_dominican-republic-abortion_1_abortion-debate-abortion-ban-dominican-republic.

⁷⁴ Women of “childbearing age” include women ages fourteen to forty-four. The Guttmacher Institute reported that 63% of women who use contraception use nonpermanent methods, primarily hormonal methods (the pill, patch, implant, injectable, and vaginal ring), the intrauterine device (IUD), and condoms. The remainder of those who use contraception rely on female or male sterilization. *Fact Sheet*, GUTTMACHER INST., http://www.guttmacher.org/pubs/fb_contr_use.html (last visited Mar. 28, 2013) [hereinafter GUTTMACHER *Fact Sheet*].

⁷⁵ Contraceptives are used to assist couples in having healthier pregnancies by being able to control the timing and spacing of pregnancies—pregnancies that occur too early, late, or close together have negative effects on maternal health and increase the risk of prematurity and low birth weight. Contraceptives provide a number of health benefits in addition to preventing unwanted pregnancies, such as treatment for excessive menstrual bleeding, menstrual pain, acne, and endometriosis. *Id.*

⁷⁶ *Griswold v. Connecticut*, 381 U.S. 479, 485 (1965).

⁷⁷ *Eisenstadt v. Baird*, 405 U.S. 438, 447 (1972); see also *Carey v. Population Servs. Int'l*, 431 U.S. 678, 678 (1977).

contraception.⁷⁸ If legal personhood began at the moment of fertilization, a woman's use of many common forms of birth control—such as intrauterine devices—could become the legal equivalent of a homicide.⁷⁹ Personhood laws could ban the use of “morning-after” pills, since scientists debate whether emergency contraception prevents implantation of a fertilized egg.⁸⁰ Keith Mason of Personhood USA claims that his personhood proposals would not restrict most forms of birth control, but acknowledges that personhood laws would prohibit contraceptives that “would kill a unique human individual.”⁸¹ Birth control pills could be viewed as, or effectively become, murder weapons, if fertilization occurs and these contraceptives prevent the fertilized egg from implanting in a woman's uterus.⁸² Dan Grossman, M.D., an obstetrician-gynecologist at the University of California, San Francisco, expressed similar concern with defining fertilized eggs as persons with legal rights— “[t]his redefinition really could end up reclassifying all of these effective and safe birth control methods as abortifacients, or agents that induce abortions.”⁸³

In sum, personhood proposals carry serious threats to women's constitutional right to access contraceptives.⁸⁴ By prohibiting the most effective and commonly used forms of contraception, personhood laws would hinder a woman's ability to make family-planning decisions and deny her safe and effective methods to protect her health.⁸⁵

⁷⁸ For example, Mississippi's Personhood Initiative 26 would have banned all abortions, barred morning-after pills and other forms of contraception such as intrauterine devices, and limited IVF procedures. See Katharine Seelye, *Voters Defeat Many G.O.P.-Sponsored Measures*, N.Y. TIMES, Nov. 9, 2011, at A20; see also Diamond, *supra* note 71 (describing how personhood legislation could place women who use contraceptives in legal jeopardy because many forms of contraceptives prevent the implantation of fertilized eggs).

⁷⁹ Diamond, *supra* note 71.

⁸⁰ Pam Belluck, *Abortion Qualms on Morning-After Pill May Be Unfounded*, N.Y. TIMES, June 5, 2012, http://www.nytimes.com/2012/06/06/health/research/morning-after-pills-dont-block-implantation-science-suggests.html?pagewanted=all&_r=0.

⁸¹ Julie Rovner, *Abortion Foes Push to Redefine Personhood*, NPR (June 1, 2011), <http://www.npr.org/2011/06/01/136850622/abortion-foes-push-to-redefine-personhood>.

⁸² Diamond, *supra* note 71. About 11 million American women use birth control pills and around 2 million use IUDs. See GUTTMACHER *Fact Sheet*, *supra* note 74. The morning-after pill and copper IUD would arguably “kill a unique human being,” i.e. a fertilized egg, because according to the FDA, both could prohibit an egg from implanting to the womb after fertilization. *Newsweek Story on ‘Personhood’ Leaders Fuels Abortion Debate*, DAILY BEAST (June 27, 2012, 7:50 PM), <http://www.thedailybeast.com/articles/2012/06/27/newsweek-story-on-personhood-leaders-fuels-abortion-debate.html>.

⁸³ Rovner, *supra* note 81 (statement of Dr. Dan Grossman, ob-gyn at the University of California, San Francisco).

⁸⁴ *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972) (“If the right of privacy means anything, it is the right of the *individual*, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child.”).

⁸⁵ Forty-three million women of childbearing age that are sexually active and capable of becoming pregnant, but do not want to become pregnant, are at risk of unintended

3. Infertility Treatment

Personhood proposals present serious threats to in vitro fertilization (IVF), a form of assisted reproductive technology (ART).⁸⁶ If personhood laws were passed, they would very likely prevent a significant number of Americans from conceiving children through IVF.⁸⁷ Under a personhood regime, physicians and patients who participate in IVF treatment may be subject to legal liability and face potential criminal charges for murder, abandonment, neglect, and conspiracy based on the nature of IVF procedures and embryo treatment.⁸⁸

Fertility centers either: (1) “freshly” implant, donate, or discard fertilized eggs; or (2) freeze fertilized eggs, which are stored for future implantation use, future donation to patients or for research, or are eventually discarded.⁸⁸ In a study published in 2010 by the *Journal of Fertility and Sterility*, researchers surveyed 1,020 IVF patients at nine fertility clinics in the United States. Among the responses, 54% of respondents with frozen embryos indicated that they were “very likely” to use them for reproduction; 21% said that they were “very likely” to donate them for research; only 7% indicated that they were “very likely” to donate embryos to another couple trying to conceive, and 6% said that they were “very likely” to thaw and dispose of the embryos.⁸⁹

pregnancy. See GUTTMACHER *Fact Sheet*, *supra* note 74. Among those women at risk of unintended pregnancy, 89% currently use contraceptives. *Id.* According to statistics, the average U.S. woman wants only two children and in order to achieve this uses contraceptives for about three decades to prevent unintended pregnancies. *Id.*

⁸⁶ See generally *In Vitro Fertilization (IVF)*, MEDLINEPLUS, <http://www.nlm.nih.gov/medlineplus/ency/article/007279.htm> (last visited Jan. 13, 2013) (defining IVF).

⁸⁷ According to the Centers for Disease Control and Prevention, fertility impairment affects 6.7 million women, ages fourteen to forty-four, in the United States. *Infertility*, CTRS. FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/nchs/fastats/fertile.htm> (last visited Jan. 13, 2013). Around 58,000 American IVF babies are born each year, constituting more than 1% of all births in the United States. Christine Russell, *Four Million Test-Tube Babies and Counting*, ATLANTIC (Oct. 7, 2010, 11:55 AM), <http://www.theatlantic.com/technology/archive/2010/10/four-million-test-tube-babies-and-counting/64198/>.

⁸⁸ The Centers for Disease Control and Prevention published a survey in 1999, which reported various treatment procedures used by IVF fertility clinics in the United States. Lab treatment of embryos and zygotes that are not implanted or frozen for future use included: 49.6% immediately discarded; 46.1% cultured to demise and discarded; 23.7% donated for research; 11.6% donated for diagnostic purposes; 22.4% donated for training purposes; and 18.5% donated to another patient/couple. ANALYTICAL SCIENCES, INC., CTRS. FOR DISEASE CONTROL & PREVENTION, FINAL REPORT: SURVEY OF ASSISTED REPRODUCTIVE TECHNOLOGY: EMBRYO LABORATORY PROCEDURES AND PRACTICES 31 (1999), available at <http://wwwn.cdc.gov/dls/pdf/art/ARTsurvey.pdf>.

⁸⁹ Anne Drapkin Lyerly et al., *Fertility Patients' Views About Frozen Embryo Disposition: Results of a Multi-Institutional U.S. Survey*, 93 FERTILITY & STERILITY 499, 499, 503 (2010); Karen Springen, *Agonizing Dilemma: A Psychologist on the Complicated Reasons Couples Are Reluctant to Donate or Destroy Stored Embryos After Their Fertility Treatments End*, DAILY BEAST (Dec. 3, 2008, 7:00 PM), <http://www.thedailybeast.com/newsweek/2008/12/03/agonizing-dilemma.html>.

Personhood laws will have a significant impact on IVF procedures, costs, and success rates.⁹⁰ Current IVF practices would likely be restricted or even banned, since to achieve successful IVF outcomes, doctors fertilize more eggs than they intend to implant and implant more embryos than can successfully survive.⁹¹ Physicians who perform IVF do not implant all the eggs that they fertilize because this can lead to risky multiple pregnancies.⁹² If personhood legislation limited physicians and patients to fertilizing only as many eggs as they plan to implant, multiple treatments to extract eggs would have to be performed, which could expose women to greater health risks, lower pregnancy rates, and potentially increase pregnancies with multiples.⁹³ Under a personhood regime, physicians and their patients could be liable for the resulting harm caused to each fertilized egg that they implant and those they do not, which are usually frozen or never used.⁹⁴ Fertility centers and patients may even be held legally responsible for finding a “willing uterus” to allow for implantation, as failure to do so could be considered negligence, abandonment, or murder. Such increased liability would also hinder a doctor’s ability to perform IVF in the safest and most effective way.⁹⁵ Fertility specialist Daniel Shapiro, M.D., expressed concern that “[a]t one extreme, [doctors] could be accused of homicide, or negligent homicide, because we’re not taking care of an embryo. At the more reasonable level, we could be considered negligent in general.”⁹⁶

⁹⁰ See Kounang, *supra* note 36; Russell, *supra* note 87.

⁹¹ See *Assisted Reproductive Technology (ART) Report: National ART Success Rates: 2010 National Summary*, CTRS. FOR DISEASE CONTROL & PREVENTION, <http://apps.nccd.cdc.gov/art/Apps/NationalSummaryReport.aspx> (last updated Jan. 6, 2012). In 2010, the percentage of “fresh,” non-frozen embryos that were transferred and resulted in implantation included: 36.5% in women under 35; 26.9% in women 35–37; 17.7% in women 38–40; 9.6% in women 41–42; and 4.2% in women 43–44. The average number of embryos transferred ranged from: 2.0 for women under 35; 2.2 for women 35–37; 2.6 for women 38–40; 3.0 for women 41–42; and 3.2 for women 43–44. Cycles which resulted in pregnancies included: 47.6% of women under 35, 38.8% of women 35–37; 29.9% of women 38–40; 19.9% of women 41–42; and 10.6% of women 43–44. *Id.*

⁹² Michelle Goldberg, *Will Mississippi Ban IVF?*, DAILY BEAST (Oct. 24, 2011, 10:25 PM), <http://www.thedailybeast.com/articles/2011/10/24/personhood-ballot-initiative-in-mississippi-could-ban-some-ivf-practices.html> (noting the position of Dr. Randall Hines, a physician who performs IVF procedures in Mississippi, on how personhood laws would affect IVF).

⁹³ See *id.* Fertility clinics may be required to perform only single-embryo implantation to ensure the most viable opportunity and environment for successful implantation and pregnancy. See *id.*

⁹⁴ See Kounang, *supra* note 36.

⁹⁵ *Id.* (describing a spokesman for the American Society of Reproductive Medicine’s opinion that giving legal and constitutional rights to an egg from the moment of fertilization will not necessarily ban IVF, but it will ban doctors from doing it in the safest and most effective way).

⁹⁶ *Id.*

Personhood USA founder Keith Mason told *Newsweek* that he does not think IVF should be banned, but rather “reformed.”⁹⁷ The full extent of IVF reform that would be required by personhood legislation remains unresolved. Based on Mason’s comments, it is reasonable to conclude that personhood laws would attach legal consequences to the creation of multiple embryos if all were not implanted, would require fair use and treatment of all embryos created, and would likely prohibit embryo freezing and destruction.⁹⁸ If human embryos were considered to be people with legal rights, then certainly freezing and storing embryos could form a basis for civil liability, criminal charges, and constitutional violations like deprivation of life and liberty without due process of the law.

In sum, personhood laws will significantly affect how embryos are created and treated at fertility centers and may hinder the quality and types of fertility treatments available to patients. Hampering access to IVF in particular may have a disparate impact on women’s healthcare and assistance with female fertility concerns. For example, cryopreservation of eggs or embryos for later use with IVF is the only method for preserving fertility for women needing cancer treatment or women with other medical indications of premature ovarian failure.⁹⁹

4. *Broader Implications for Women’s Liberty and Equality in Healthcare Decision-Making*

Personhood laws would do much more than ban all abortion care, hinder access to medical care for pregnant women, bar some of the most effective methods of contraception, and impede fertility treatments such as IVF. If the law declared that legal personhood begins at fertilization and thus a zygote has equal or similar rights to the woman carrying it, pregnant women could be regulated in any number of ways. The implications for women’s liberty and equality, particularly in their healthcare decision-making during pregnancy, are wide ranging—from criminalization of behavior during pregnancy, to family-law implications for spousal control over pregnant women’s medical treatment decisions, to employment-law practices regarding pregnancy discrimination. This section briefly sketches out a few of these potential implications.

Personhood laws would authorize much more extensive regulation of pregnant women and their healthcare decisions. The policing of pregnant

⁹⁷ Pesta, *supra* note 60, at 21. Mason also told CNN.com that “[i]n creating 30 to 60 embryos, and then choosing three or four embryos, that’s selective reduction. I think these practices would be affected.” Kounang, *supra* note 36 (internal quotation marks omitted). In response to Mason’s position, Dr. Daniel Shapiro, a fertility specialist, noted that women under thirty-five usually generate only eight to ten embryos in a cycle, where one or two are transferred for possible implantation, and about three embryos are usually frozen. *Id.*

⁹⁸ See Kounang, *supra* note 36; Pesta, *supra* note 60, at 21.

⁹⁹ See Jack Yu Jen Huang et al., *In Vitro Fertilisation Treatment and Factors Affecting Success*, 26 BEST PRAC. & RES. CLINICAL OBSTETRICS & GYNAECOLOGY 777, 780 (2012).

women's behavior through miscarriage investigations, court-ordered Caesarean sections, punishment for drug use during pregnancy, and other regulation of behavior during pregnancy all could be justified under a zygote personhood regime. In fact, even without personhood laws in place, criminal sanctions or the threat of criminal sanctions have been used to control pregnant women's conduct in violation of their rights to bodily integrity, autonomous decision-making, and equal treatment under the law.¹⁰⁰

Under personhood laws, the State could have the power to investigate and prosecute women who have miscarriages if they suspect homicide.¹⁰¹ A woman's doctor may be inclined, if not required, to report a woman's harmful conduct to the police.¹⁰² Even a woman who is unaware that she is pregnant, but acts in a way that results in a miscarriage, could also be charged with involuntary manslaughter. Any of the following actions could result in prosecution of a pregnant woman if she induces or contributes to a miscarriage: (1) drinking too much alcohol;¹⁰³ (2) falling down the stairs;¹⁰⁴ (3) failing to wear a seatbelt and then getting in an accident;¹⁰⁵ (4) smoking;¹⁰⁶ (5) drug

¹⁰⁰ See Lynn M. Paltrow & Jeanne Flavin, *Arrests of and Forced Interventions on Pregnant Women in the United States, 1973–2005: Implications for Women's Legal Status and Public Health*, 38 J. HEALTH POL., POL'Y & L. 299, 300, 303 (2013) (analyzing 413 cases in which pregnancy was a key factor in the deprivation of a woman's physical liberty); Lynn M. Paltrow, *Roe v. Wade and the New Jane Crow: Reproductive Rights in the Age of Mass Incarceration*, 103 AM. J. PUB. HEALTH 17, 18–19 (2013) (discussing cases criminalizing behavior during pregnancy and implications for women's constitutional rights).

¹⁰¹ See Rep. Carl Wimmer's HB 12, "Abortion Amendments" Could Impact Pregnant Women Who Aren't Even Seeking an Abortion, AM. CIVIL LIBERTIES UNION OF UTAH, <http://www.acluutah.org/HB12.htm> (last visited Jan. 4, 2013) [hereinafter *Rep. Carl Wimmer's HB 12*].

¹⁰² Such laws already exist. See, e.g., MINN. STAT. §§ 626.5561, 626.5562 (2012) (requiring doctors to report pregnant patients' use of alcohol and controlled substances during pregnancy and mandating toxicology testing of mothers and newborns shortly after delivery if there is reason to believe the mother has used harmful substances).

¹⁰³ Carolyn B. Ramsey, *Restructuring the Debate Over Fetal Homicide Laws*, 67 OHIO ST. L.J. 721, 735 (2006).

¹⁰⁴ See, e.g., Amie Newman, *Pregnant? Don't Fall Down the Stairs*, RH REALITY CHECK (Feb. 15, 2010, 5:07 PM), <http://www.rhrealitycheck.org/blog/2010/02/15/its-illegal-37-states-for-a-pregnant-woman-fall-down-stairs>. This article describes the story of Christine Taylor, a pregnant mother of two from Iowa who fell down a flight of stairs after becoming light-headed and subsequently went to the hospital to make sure her fetus had not been harmed. Taylor told the treating nurse that she was not sure if she wanted to continue the pregnancy since her husband left her once he found out she was pregnant for the third time. The nurse communicated this information to the doctor who then called the police. The police came to the hospital, arrested Taylor, and put her in jail. *Id.*

¹⁰⁵ See Nathan Black, *Utah Bill Criminalizing Illegal Abortions Sparks Debate*, CHRISTIAN POST: CP POLITICS (Mar. 1, 2010, 5:50 PM), <http://www.christianpost.com/news/utah-bill-criminalizing-illegal-abortions-sparks-debate-44026/>.

¹⁰⁶ Ramsey, *supra* note 103, at 735.

use;¹⁰⁷ and (6) missing prenatal care appointments.¹⁰⁸ Personhood laws could lead to criminalization of a pregnant woman's actions that are perceived as harmful or reckless acts towards her fetus and would prejudice pregnant women who are victims of domestic violence, who by returning to an abuser would arguably place the fetus in harm's way.¹⁰⁹ In most cases, it is not medically possible to accurately identify the cause of a miscarriage or stillbirth.¹¹⁰ This medical fact is troubling, when personhood laws could arguably impose liability on pregnant women for any actions that could potentially result in a miscarriage. In other countries with laws akin to personhood legislation, miscarriage investigations are common.¹¹¹

If physicians and state officials view a pregnant woman's healthcare choices as a danger to her fetus, courts may order a pregnant woman to be detained until she gives birth or undergo medical treatment to protect the fetus.¹¹² "[C]ourt-ordered detentions and medical interventions are contrary to the prevailing view of medical professionals that medical treatment against the pregnant woman's wishes is rarely, if ever, appropriate."¹¹³ However, personhood laws seem likely to instigate increased investigation, prosecution,

¹⁰⁷ Lisa McLennan Brown, *Feminist Theory and the Erosion of Women's Reproductive Rights: The Implications of Fetal Personhood Laws and In Vitro Fertilization*, 13 AM. U. J. GENDER SOC. POL'Y & L. 87, 95 (2005) ("In May 2001, a South Carolina jury after fourteen minutes of deliberation convicted Regina McKnight of homicide by child abuse, after she gave birth to a stillborn baby and admitted to crack-cocaine use while pregnant."); see also Dana Page, Note, *The Homicide by Child Abuse Conviction of Regina McKnight*, 46 HOW. L.J. 363, 363–69 (2003) (describing South Carolina's criminal prosecution and conviction of Regina McKnight and the state's trend of criminally prosecuting poor pregnant black women who are addicted to crack).

¹⁰⁸ Rep. Carl Wimmer's HB 12, *supra* note 101.

¹⁰⁹ Brandon Loomis, *Measure on Illegal Abortions Heads to Governor*, SALT LAKE TRIB. (Feb. 18, 2010, 6:18 PM), http://www.sltrib.com/news/ci_14429070.

¹¹⁰ *Miscarriage*, AM. PREGNANCY ASS'N, <http://www.americanpregnancy.org/pregnancycomplications/miscarriage.html> (last updated Nov. 2011).

¹¹¹ See Michele Stopera Freyhauf, *Criminalizing Miscarriages: Latin America's Zero Tolerance Policy on Abortion*, FEMINISM & RELIGION, <http://feminismandreligion.com/2011/10/06/criminalizing-miscarriages-latin-america's-zero-tolerance-policy-on-abortion-by-michele-stopera-freyhauf/> (last visited Oct. 6, 2011) (describing Latin America's criminalization of miscarriages and imprisonment of women who suffer spontaneous abortions).

¹¹² See, e.g., Linda C. Fentiman, *The New "Fetal Protection": The Wrong Answer to the Crisis of Inadequate Health Care for Women and Children*, 84 DENV. U. L. REV. 537, 567–68 (2006) (describing the case of "Rebecca Corneau, a pregnant woman who rejected all medical care" and was believed to be a danger to her fetus due to her suspected membership in a religious cult). A Massachusetts family court judge ordered Ms. Corneau to be sent to a prison hospital and ordered her to submit to medical examination to determine the health of her fetus. Ms. Corneau was imprisoned up until her child's birth, where the child was deemed neglected and Corneau stripped of her parental rights. *Id.*

¹¹³ *Id.* at 569.

regulation, and control over a pregnant woman's autonomy for the sake of protecting her fetus.¹¹⁴

Concern over the criminalization of pregnant women is not overstated, as evidenced by existing case law punishing or threatening criminal punishment of pregnant women. These legal actions attempt to control women's "reproductive capability by raising the specter of civil or criminal liability if they engage in potentially risky activities before or during pregnancy."¹¹⁵ For example, in two different cases prosecutors brought murder charges against women who delivered stillborn infants, one based on a woman's drug use during her pregnancy¹¹⁶ and the other based on a woman's refusal to have a Caesarean section.¹¹⁷ Both cases illustrate that prosecutors and the courts are already adamant about regulating the behavior of pregnant women because of their pregnant status and choices made during their pregnancy. Even under existing law that allegedly protects pregnant women's autonomy in medical decision-making, forced C-section cases are surprisingly common.¹¹⁸ In light of these

¹¹⁴ See Beety, *supra* note 67, at 60–61 (describing how the death of an embryo or fetus, considered to be a citizen under a personhood law, would affect pregnant women). "In states that neither constitutionally nor statutorily recognize a fetus as a citizen, there are cases of pregnant women facing charges of harming the fetus. This evidences heightened surveillance in general, and criminal investigation in particular, of acts that may harm an unborn child." *Id.* at 60 (footnote omitted).

¹¹⁵ Fentiman, *supra* note 112, at 540.

¹¹⁶ In 1999, Regina McKnight, a homeless, arguably mentally retarded pregnant woman addicted to cocaine, was charged with murder after giving birth to a stillborn child. The Supreme Court of South Carolina affirmed her murder conviction and upheld the twenty-year sentence imposed. *State v. McKnight*, 576 S.E.2d 168, 171 (S.C. 2003); Page, *supra* note 107, at 368–69.

¹¹⁷ Pamela Manson, *Mother Is Charged in Stillborn Son's Death*, SALT LAKE TRIB., Mar. 12, 2004, at A1; see also Fentiman, *supra* note 112, at 554–55 (noting that when charging the mother with murder, prosecutors argued that the mother's failure to follow the advice of doctors and undergo a C-section constituted a culpable omission which demonstrated "depraved indifference to human life"; the mother spent three months in jail and under a plea bargain pleaded guilty to two counts of felony child endangerment due to her drug use during pregnancy).

¹¹⁸ See Lisa L. Chalidze, *Misinformed Consent: Non-medical Bases for American Birth Recommendations as a Human Rights Issue*, 54 N.Y.L. SCH. L. REV. 59, 77 (2010). There is an extensive literature critiquing the practice of forced Caesarean sections and, relatedly, punishment aimed at pregnant women who refuse medical treatment. See, e.g., Lisa C. Ikemoto, *Furthering Inquiry: Race, Class, and Culture in the Forced Medical Treatment of Pregnant Women*, 59 TENN. L. REV. 487, 502–04 (1992) (analyzing forced medical treatment cases); Michelle Oberman, *Mothers and Doctors' Orders: Unmasking the Doctor's Fiduciary Role in Maternal-Fetal Conflicts*, 94 NW. U. L. REV. 451, 451 n.4 (2000) (noting the rich literature on "maternal-fetal" conflicts); Nancy K. Rhoden, *The Judge in the Delivery Room: The Emergence of Court-Ordered Cesareans*, 74 CALIF. L. REV. 1951, 1951–52, 1962, 1965 (1986) (discussing *Jefferson v. Griffin Spalding Cnty. Hosp. Auth.*, 274 S.E.2d 457, 458–61 (Ga. 1981), where the Supreme Court of Georgia upheld a trial judge's order for a pregnant woman to undergo a Caesarean section, despite her religious objections to the procedure, based on doctors' concerns for the fetus' health). Notably, many

cases, criminal prosecution of pregnant women under a personhood regime would likely increase for instances where such women fail to act in ways that would benefit their fetus,¹¹⁹ as well as when pregnant women act in ways that could risk harm to, does harm, or terminates their pregnancy.¹²⁰

Personhood laws could also have implications in family law. Family law generally grants fit parents equal rights to custody and control of their born children's upbringing.¹²¹ In *Planned Parenthood of Southeastern Pennsylvania v. Casey*, the Court reviewed the constitutionality of a state spousal-notification law to abortion.¹²² *Casey* opined that "[t]he husband's interest in the life of the child that his wife is carrying does not permit the State to empower him with this troubling degree of authority over his wife."¹²³ The Court discussed the slippery slope that would result if a husband's interest in the life of the fetus his wife is carrying would require that his wife give him notice to any action of hers that would potentially harm the fetus.¹²⁴ Under a personhood regime, if the embryo constitutes a legal person with the same status as a born child, fathers could have the very rights of dominion over pregnant women that *Casey* rejected. Custody battles between men and women under a personhood regime could also be altered. For example, if a woman acts in a harmful way to the embryo while pregnant, the father may offer evidence of such acts against the

of the cases involving forced Caesarean sections or forced medical treatment involve poor women of color. See DOROTHY ROBERTS, *KILLING THE BLACK BODY: RACE, REPRODUCTION AND THE MEANING OF LIBERTY* 305 (1997); Lisa C. Ikemoto, *The Code of Perfect Pregnancy: At the Intersection of the Ideology of Motherhood, The Practice of Defaulting to Science, and the Interventionist Mindset of Law*, 53 OHIO ST. L.J. 1205, 1260 (1992) (discussing regulation of pregnant women and noting targeting of poor women of color).

¹¹⁹ See, e.g., Beety, *supra* note 67, at 56 (noting that the state of Mississippi, even without a personhood law, prosecutes pregnant women for "unintentional, harmful acts toward a fetus").

¹²⁰ See, e.g., *id.* at 55–56 ("[Alabama] prosecutes pregnant women who test positive for drugs while at the hospital, even if they are giving birth to apparently healthy newborns."); see also Michele Goodwin, *Prosecuting the Womb*, 76 GEO. WASH. L. REV. 1657, 1661 (2008) (describing how fetal drug laws are ineffective and exempt behaviors of affluent groups); Matt Eloffson, *Defining a Crime: Treatment or Prosecution for Moms When Newborns Test Positive for Drugs?*, SUNDAY DOTHAN EAGLE (Ala.), Oct. 24, 2010, at 1A.

¹²¹ See D. Kelly Weisberg & Susan Frelich Appleton, *MODERN FAMILY LAW: CASES AND MATERIALS* 683–89 (2010) (discussing child custody rights and best interests of the child standard).

¹²² *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 844–45 (1992).

¹²³ *Id.* at 898.

¹²⁴ *Id.* ("If a husband's interest in the potential life of the child outweighs a wife's liberty, the State could require a married woman to notify her husband before she uses a postfertilization contraceptive. Perhaps next in line would be a statute requiring pregnant married women to notify their husbands before engaging in conduct causing risks to the fetus. After all, if the husband's interest in the fetus' safety is a sufficient predicate for state regulation, the State could reasonably conclude that pregnant wives should notify their husbands before drinking alcohol or smoking. Perhaps married women should notify their husbands before using contraceptives or before undergoing any type of surgery that may have complications affecting the husband's interest in his wife's reproductive organs.").

mother's interest in retaining her parental rights and custody of the child at the custody hearing, as states already do in dependency proceedings.¹²⁵

Finally, personhood laws also raise implications for women's decisions about their health in the workplace and fair employment practices. Federal law prohibits pregnancy discrimination in the workplace.¹²⁶ In *UAW v. Johnson Controls*, the U.S. Supreme Court held that employers cannot deny women jobs in order to protect their future fetuses.¹²⁷ The employer in that case refused to employ women of childbearing age for certain jobs because of potential hazards from chemical exposure.¹²⁸ The *Johnson Controls* Court emphasized that embryos would not be recognized as third parties whose safety was essential to the business.¹²⁹ If embryos are accorded the same legal status as women, personhood laws "threaten[] to limit women's ability to participate in the workforce"¹³⁰ Under a personhood regime, employers may institute similar exclusion policies as the policy challenged in *Johnson Controls* simply because of women's capacity to become pregnant. Given the risk of substantial tort liability under a legal regime granting personhood to embryos, employers may argue that embryo-protection policies are justified to ensure that female workers

¹²⁵ See, e.g., Fentiman, *supra* note 112, at 581 ("[A]ll states agree that a woman's use of alcohol or other drugs while pregnant is a proper trigger for taking custody of a child as 'neglected,' and may be the basis for terminating her parental rights."). Some state statutes explicitly authorize courts to consider prenatal substance abuse. See, e.g., COLO. REV. STAT. § 19-3-102(1)(g) (2012) (declaring that a child is neglected or dependent if it is born with controlled substances in its system); OKLA. STAT. tit. 10A, § 1-1-105(20)(e) (Supp. 2012) (declaring that a child born dependent on controlled substance is a "deprived child"). Other states have achieved the same result through judicial interpretation of more general child neglect criteria. See, e.g., *In re Troy D.*, 263 Cal. Rptr. 869, 872 (Cal. Ct. App. 1989) (applying CAL. WELF. & INST. CODE § 300(a) (West 2008) to a child born to a mother who ingested drugs during pregnancy); *In re Baby Boy Blackshear*, 736 N.E.2d 462, 465 (Ohio 2000) (holding that a newborn with a positive toxicology screen is per se an abused child under the Ohio civil child abuse statute); see also *In re Stefanel Tyesha C.*, 556 N.Y.S.2d 280, 282–83 (N.Y. App. Div. 1990) (quoting N.Y. FAM. CT. ACT § 1046(a)(iii) (1975)) (holding that allegations that a mother admitted drug use while pregnant and that her infant had a positive toxicology test are sufficient to permit a child neglect proceeding to go forward).

¹²⁶ In 1978, Congress amended Title VII of the Civil Rights Act of 1964 to enact the Pregnancy Discrimination Act (PDA). *The Pregnancy Discrimination Act*, AM. ASS'N OF UNIV. WOMEN, <http://www.aauw.org/act/laf/library/pda.cfm> (last visited Jan. 11, 2013); see also 42 U.S.C. § 2000e(k) (2006).

¹²⁷ *UAW v. Johnson Controls*, 499 U.S. 187, 190–92, 210–11 (holding that an employer could not refuse to employ women who were of childbearing age for certain jobs because of potential hazards to a fetus that might result from exposure to chemicals in the workplace).

¹²⁸ *Id.* at 191–92.

¹²⁹ *Id.* at 203–04.

¹³⁰ See Fentiman, *supra* note 112, at 540.

do not cause injury to their future children while performing the functions of their jobs.¹³¹

* * *

The implications of personhood legislation reach far beyond the particular context of abortion. As I discuss below, concerns over these side effects, particularly on women's healthcare other than abortion, appear to be one key reason for the overwhelming failure of the current personhood movement in spite of strong support for abortion restrictions across many states.

B. *The Defeat of Personhood Proposals*

Given the wide variety of contexts in which personhood proposals have been put forward, it is difficult to reach a definitive conclusion on why the personhood movement has yet to succeed in enacting any laws despite hostility to abortion rights in many jurisdictions and among many state legislators. However, observers of the personhood movement have suggested that personhood laws have failed because of the broader implications of such legislation described above. In other words, it was not support for abortion but concern over allegedly "unintended consequences" on women's health and healthcare decision-making that has doomed personhood proposals.¹³² In contrast, laws that appear to only target abortion are much more politically acceptable due to the stigma surrounding abortion.¹³³

For example, legislators in Virginia, although eager to push through other types of stringent abortion restrictions such as mandatory ultrasounds and burdensome clinic regulations, rejected the Virginia Personhood Bill.¹³⁴ It appears that the Virginia personhood proposal failed because a coalition of

¹³¹ See, e.g., Wendy W. Williams, *Firing the Woman to Protect the Fetus: The Reconciliation of Fetal Protection with Employment Opportunity Goals Under Title VII*, 69 GEO. L.J. 641, 641–43 (1981).

¹³² See Patrik Jonsson, *Mississippi 'Personhood' Measure: Why Support Waned as Election Day Neared*, CHRISTIAN SCI. MONITOR, Nov. 8, 2011, at 13. Of course, not all of these "side effects" are unintended. Some proponents of personhood laws are in favor of limiting access to contraception and IVF. Furthermore, numerous scholars have argued that limitations on reproductive rights are one component of a worldview in favor of enforcing traditional gender roles and traditional limits on sexuality and the family. See, e.g., KRISTIN LUKER, *ABORTION AND THE POLITICS OF MOTHERHOOD* 161–62 (1984).

¹³³ See generally Jenny O'Donnell, Tracy A. Weitz & Lori R. Freedman, *Resistance and Vulnerability to Stigmatization in Abortion Work*, 73 SOC. SCI. & MED. 1357 (2011) (discussing stigma surrounding abortion for both patients and providers).

¹³⁴ See John Celock, *Virginia Personhood Bill: State Senate Defeats Bill*, HUFFINGTON POST (Feb. 23, 2012, 6:40 PM), http://www.huffingtonpost.com/2012/02/23/virginia-personhood-bill-defeated-senate_n_1297463.html; *Monthly State Update: Major Developments in 2012*, GUTTMACHER INST. (Dec. 31, 2012), <http://www.guttmacher.org/statecenter/updates/index.html>.

patients, medical associations, and women's organizations convinced legislators that the law would result in the ban of IVF infertility treatment in Virginia and also put at risk the legality of terminating life-threatening ectopic pregnancies.¹³⁵

The failure of the personhood ballot initiative in Mississippi—"arguably the most conservative state in the Union"¹³⁶—illustrates the importance of linking personhood laws to medical issues other than abortion. Measure 26, as the proposal was known in Mississippi, would have amended the Bill of Rights of the Mississippi Constitution to define the term "person" or "persons" to "include every human being from the moment of fertilization, cloning, or the functional equivalent thereof."¹³⁷ A month before the election, the personhood initiative was polling at 80% approval. Yet, "Mississippi voters ultimately rejected the personhood measure in an upset vote of 58 to 41%."¹³⁸ Commentators identified several explanations for the surprising failure of Measure 26, but "the two most common reasons indicated for voting against the initiative had to do with potential implications for (a) the medical treatment of pregnant women (28%), and (b) the availability of IVF (31%)."¹³⁹ One report noted that "[i]n Mississippi, concerns that the measure would empower the government to intrude in intimate medical decisions far afield from abortion—involving not just infertility, but also birth control, potentially deadly ectopic pregnancies and the treatment of pregnant women with cancer—were decisive in its defeat."¹⁴⁰ Ironically, the personhood movement's attempt to vilify abortion by personifying the fetus may have educated the public about the importance of preserving access to abortion care in order to preserve access to less stigmatized forms of healthcare.

¹³⁵ See Martin H. Johnson, Geddis Grudzinskas & Jacques Cohen, *Personhood: To Be or When to Be—Is that the Question?*, 24 REPROD. BIOMEDICINE ONLINE 687, 687 (2012).

¹³⁶ Burns Strider, *6 Reasons Mississippians Said No to "Personhood" Amendment*, HUFFINGTON POST (Nov. 8, 2011, 10:46 PM), http://www.huffingtonpost.com/burns-strider/personhood-amendment-_b_1083079.html.

¹³⁷ Initiative Measure No. 26 (Miss. 2010), available at <http://www.sos.ms.gov/page.aspx?s=7&s1=1&s2=50>.

¹³⁸ Collins & Crokin, *supra* note 28, at 690.

¹³⁹ Jonathan F. Will, *Beyond Abortion: Why the Personhood Movement Implicates Reproductive Choice* 18 (Miss. Coll. Sch. of Law, Legal Studies Research Paper No. 2012-05, 2012) (footnote omitted), available at <http://ssrn.com/abstract=2139072>; see also Irin Carmon, *How Mississippi Beat Personhood*, SALON (Nov. 9, 2011, 7:30 AM), http://www.salon.com/2011/11/09/how_mississippi_beat_personhood/ (noting that one of the most visible activists opposed to Initiative 26 was Atlee Breland, whose efforts focused on the measure's effective prohibition of IVF); Strider, *supra* note 136.

¹⁴⁰ Denise Grady, *Medical Nuances Drove 'No' Vote in Mississippi*, N.Y. TIMES, Nov. 15, 2011, at D1; see also Jonsson, *supra* note 132, at 13 (stating that "the greatest drag on support for the measure . . . may be misgivings from the state's medical community about potential unintended consequences" including that "lawyers and judges would be making decisions about women's health").

Similar concerns were raised in Colorado regarding the potential impact of a personhood measure on medical “treatment of pregnant women, restrictions on contraception, and restrictions on IVF.”¹⁴¹ In Colorado, the birthplace of Personhood USA, voters have twice rejected personhood ballot initiatives.¹⁴² Opponents of the Colorado personhood amendments believed that their anti-personhood campaigns succeeded because they “educat[ed] voters on the far-reaching consequences” of the measure on issues other than abortion, such as “treatment for miscarriages, tubal pregnancies and infertility.”¹⁴³ Pro-choice advocates fighting personhood measures are aware of the risks in presenting personhood proposals purely as abortion measures and instead frame the problem more broadly as implicating other women’s health issues—a strategy that appears to have been widely successful.

Thus, these ongoing battles over personhood laws have provided a useful opportunity for reproductive rights advocates to re-link abortion with other aspects of women’s health and to elucidate how attacks purportedly targeted at abortion negatively affect women’s access to healthcare in a broader sense. In fact, existing anti-abortion laws and policies already impinge upon women’s health beyond the abortion context, but these “side effects” remain masked. In the next Part, I examine how current abortion restrictions detrimentally impact women’s healthcare even for those women not actively seeking abortion care.

IV. THE SIDE EFFECTS OF EXISTING ABORTION RESTRICTIONS

While legislators and the public (even in strongly anti-abortion states) have expressed concern about anti-abortion laws that impede women’s healthcare in the context of personhood proposals, a similar understanding of the healthcare implications of other types of abortion restrictions has not yet developed. Part of the popularity of anti-abortion measures rests on the faulty belief that those laws affect only the “bad” women who seek abortions. This belief rests on the false assumption that abortion can be isolated from other aspects of women’s health. In this Part, I demonstrate that, as a matter of medical reality, abortion cannot be isolated from the continuum of women’s healthcare. Thus far, the public appears to have recognized this reality in the context of personhood legislation, but has otherwise failed to understand the interconnectedness of abortion care with women’s health generally. In fact, various existing abortion restrictions already obstruct women’s healthcare, but these harmful “side effects” remain hidden from view. Below, I describe how existing anti-abortion government regulation detrimentally affects care for women in the context of miscarriage management, prenatal care, and treatment of ectopic pregnancies.

¹⁴¹ See Will, *supra* note 139, at 17.

¹⁴² See Steven Ertelt, *Colorado Personhood Amendment Fails to Qualify for Third Vote*, LIFE NEWS.COM (Aug. 29, 2012, 1:36 PM), <http://www.lifenews.com/2012/08/29/colorado-personhood-amendment-fails-to-qualify-for-third-vote/>.

¹⁴³ Electa Draper, “Personhood” Initiative Sinks by 3-1 Margin, DENVER POST, Nov. 3, 2010, at 2B.

A. "Partial-Birth" Abortion Bans and Miscarriage Management

In 2003, Congress enacted the first federal abortion regulation, a ban on "partial-birth" abortion, which does not contain an exception to protect women's health.¹⁴⁴ The statute purports to ban a method of second trimester abortion called "partial-birth" abortion by its opponents, but known medically as "intact D&E."¹⁴⁵ "Partial-birth" abortion is not a medical term, but a political one.¹⁴⁶ Although the federal "partial-birth" abortion ban received much attention when the Supreme Court upheld the law in *Gonzales v. Carhart*, the public has heard little about the effects of this ban since its implementation. The discussion of the law during the years of litigation gave the impression that a ban on intact D&E would only affect a small number of women seeking abortions late in their pregnancy. In fact, research on the consequences of the federal "partial-birth" abortion ban for women's health suggests a much wider impact not only on abortion care, but also in the management of miscarriages.¹⁴⁷

Lori Freedman, a leading researcher on the effects of anti-abortion policies on physicians, found that some physicians who do not routinely provide

¹⁴⁴ See Partial-Birth Abortion Ban Act of 2003, Pub. L. No. 108-105, § 1531(a), 117 Stat. 1201, 1206 (2003); Nat'l Abortion Fed'n v. Ashcroft, 330 F. Supp. 2d 436, 492 (S.D.N.Y. 2004) (holding the ban unconstitutional for lack of an exception for women's health); Cynthia Dailard, *Courts Strike 'Partial-Birth' Abortion Ban; Decisions Presage Future Debates*, GUTTMACHER REP. ON PUB. POL'Y, Oct. 2004, at 1-2 (discussing the federal ban and three district court decisions that struck down the statute).

¹⁴⁵ See *Gonzales v. Carhart*, 550 U.S. 124, 136-37, 150-51 (2007). *Carhart* concluded that the federal abortion ban criminalizes the intentional use of only one method of second-trimester abortion, "intact D&E," but the medical literature labels this same procedure with various names: "intact D&E," "intact D&X," or "D&X." *Id.* This Article will refer to the procedure as "intact D&E." In a D&E procedure, the physician evacuates the fetus and placenta using forceps. In an intact D&E procedure, the physician evacuates the fetus, but accomplishes the evacuation with the fetus largely intact. See *Carhart v. Ashcroft*, 331 F. Supp. 2d 805, 852-99 (D. Neb. 2004), *aff'd sub nom. Carhart v. Gonzales*, 413 F.3d 791 (8th Cir. 2005), *rev'd* 550 U.S. 124 (2007) (detailing district court findings of fact describing doctor's testimony regarding abortion procedures).

¹⁴⁶ See Cynthia Gorney, *Gambling with Abortion: Why Both Sides Think They Have Everything to Lose*, HARPER'S MAG., Nov. 2004, at 33-34.

¹⁴⁷ For research on the effects of the ban on abortion care, see Lisa Haddad et al., *Changes in Abortion Provider Practices in Response to the Partial-Birth Abortion Ban Act of 2003*, 79 CONTRACEPTION 379, 381-383 (2009) (finding changes in abortion practices reflecting adherence to legal mandates rather than new scientific evidence), and Tracy A. Weitz & Susan Yanow, *Implications of the Federal Abortion Ban for Women's Health in the United States*, 16 REPRODUCTIVE HEALTH MATTERS 99, 103 (2008) (noting that medical experts have stated that adequate dilation is "a critical factor in the safety of any D&E" and the Court's emphasis on dilation as proof of intent to perform the banned intact D&E procedure "may lead some providers not to dilate adequately for fear of appearing to induce an intact D&E").

abortions are nevertheless impacted by the ban.¹⁴⁸ She related the story of one physician who attempted to care for a patient who was miscarrying a previable pregnancy but felt unable to treat her patient in the safest manner she thought possible for fear of violating the law. The physician, who told this story confidentially, explained how the patient was losing a twenty-two-week pregnancy due to ruptured membranes and her treatment as follows:

Dr. B: "[The patient] was kind of in the process of delivering but it wasn't coming fast enough and she's trying to hemorrhage to death. . . . So I took her to the OR to basically do a D&E . . . so I could get her to quit hemorrhaging. Well, you know the whole thing about the partial birth abortion. I mean, [it's] being born breach, it's still kicking, it still has a heartbeat, its head is stuck in her cervix. What would make sense would be to punch a hole in the back of its skull, collapse its brain, get it out of there and save the patient. But you've got all these people in the OR that don't know what the background situation [is]. . . . And it's just like that would've made perfect sense to do that but I didn't primarily because I was worried that all these, you know, the techs and circulating nurses in the OR are going to think, 'Oh, Dr. B is a baby killer,' you know, 'And she just did a partial birth abortion and doesn't everybody know that's illegal?'"¹⁴⁹

In fact, technically this situation would not fall within the scope of the federal "partial-birth" abortion ban, since the physician did not start the procedure with an intent to perform an intact D&E.¹⁵⁰ Nevertheless, regardless of the technicalities of the law, the law's effect has been to create a system in which doctors feel circumscribed in the exercise of their medical judgment.¹⁵¹ Professor Tracy Weitz argues that the law has become its own "Panopticon," a perpetual surveillance system where "physicians make decisions in the operating room based on their fears about who might be watching, worried that onlookers will misinterpret the situation."¹⁵² As with personhood laws, the federal "partial-birth" abortion ban has side effects, inhibiting not just abortion care but also the care of pregnant women suffering from miscarriages.

In this particular case, the physician completed a disarticulation D&E (non-intact D&E) and was able to save the patient's life.¹⁵³ However, we do not know how often circumstances like these arise and at what risks to patients, because these stories are rarely told.¹⁵⁴ The federal "partial-birth" abortion ban

¹⁴⁸ See Tracy A. Weitz, *Lessons for the Prochoice Movement from the 'Partial Birth Abortion' Fight*, XXXIII CONSCIENCE, no. 1, 2012, at 26, 28.

¹⁴⁹ *Id.* at 28 (quoting from a presentation by Lori Freedman) (alteration in original).

¹⁵⁰ *See id.*

¹⁵¹ *See id.*

¹⁵² *Id.*

¹⁵³ *See id.*

¹⁵⁴ See Weitz, *supra* note 148; see also Lori R. Freedman, Uta Landy & Jody Steinauer, *When There's a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals*, 98 AM. J. PUB. HEALTH 1774, 1777-78 (2008) [hereinafter Freedman et al., *When There's a*

and similar state bans leave physicians with a Hobson's choice—even in medical situations where abortion care was not intended or sought—pitting physicians' medical judgment of what procedures would best protect their patients' health against the threat of criminal sanction.

B. Information Control and Prenatal Care

The regulation of information surrounding abortion care also has spillover effects on women's prenatal care. As described earlier, one increasingly popular method of regulating abortion has been the control of information in the context of abortion care.¹⁵⁵ The law effectuates information control as reproductive control not only with biased information and forced information such as mandatory ultrasounds, but also with denials of information. Surprisingly little attention has been paid to laws denying information to pregnant women, which affects all women seeking prenatal care rather than just women seeking abortion care.¹⁵⁶

Oklahoma provides one stark example of information control as reproductive control. On the same day that Oklahoma passed legislation mandating that abortion patients undergo a forced ultrasound, it also passed a law protecting from tort liability physicians who fail to disclose fetal anomalies to prenatal patients.¹⁵⁷ In other words, Oklahoma law forces unwanted information on some pregnant patients, while at the same time empowering physicians to conceal wanted information from others.¹⁵⁸ Furthermore, under this liability-preclusion law, physicians have no duty to disclose to their patients that they would intentionally hide information about fetal anomalies.¹⁵⁹ Proponents of this law claim that precluding liability for doctors who fail to

Heartbeat] (stating that it may be difficult to assess how often physicians alter their medical judgment to accommodate anti-abortion policies, or violate hospital policies to ensure safe care for patients, "because most physicians are not likely to discuss such behavior even in a confidential interview").

¹⁵⁵ See *supra* Part II.D (discussing rise in abortion restrictions such as biased "informed consent" regulations and mandatory ultrasounds).

¹⁵⁶ An Oklahoma law permitting physicians to conceal material information from prenatal patients has not yet been subject to challenge in the courts; however, Oklahoma's mandatory ultrasound law has been struck down as unconstitutional by the Oklahoma Supreme Court. See *Nova Health Sys. v. Pruitt*, 292 P.3d 28, 28–29 (Okla. 2012).

¹⁵⁷ See 2010 Okla. Sess. Law Serv. ch. 173 (West); 2010 Okla. Sess. Law Serv. ch. 171 (West).

¹⁵⁸ See *id.* A small number of other states also have similar limitations on "wrongful birth" claims. See Julie Gantz, Note, *State Statutory Preclusion of Wrongful Birth Relief: A Troubling Re-Writing of a Woman's Right to Choose and the Doctor-Patient Relationship*, 4 VA. J. SOC. POL'Y & L. 795, 812–20 (1997) (summarizing statutory law and case law on wrongful birth claims); Jillian T. Stein, Comment, *Backdoor Eugenics: The Troubling Implications of Certain Damages Awards in Wrongful Birth and Wrongful Life Claims*, 40 SETON HALL L. REV. 1117, 1131–35 (2010) (summarizing law on wrongful birth claims).

¹⁵⁹ See OKLA. STAT. tit. 63, § 1-741.12 (Supp. 2012).

reveal material information that they otherwise would have a duty to disclose under standard principles of informed consent only thwarts women who would seek an abortion if they knew of a fetal anomaly.¹⁶⁰ Thus, proponents argue that liability preclusion laws of this sort are only anti-abortion measures.¹⁶¹

In reality, laws that permit denying information in the context of prenatal care affect not only those women who may consider terminating a pregnancy, but also those who would not choose an abortion but could use the information to plan for their families. Dr. Rina Anderson's story illustrates this point.¹⁶² Dr. Anderson worked in private practice after her ob-gyn residency.¹⁶³ Her practice allowed her to provide pregnancy terminations in cases of fetal anomalies.¹⁶⁴ Dr. Anderson regularly performed second-trimester abortions in these circumstances.¹⁶⁵ Unfortunately, she found herself faced with making the same difficult decision as her patients when, during her second trimester of pregnancy, she discovered that her baby had a fatal diagnosis.¹⁶⁶ Describing her own loss, Dr. Anderson explained how she made a choice that surprised even her:

Actually, with our daughter we were faced with the same decision. And in the end we actually ended up choosing perinatal hospice. Kind of funny, how life takes you. We got all of her diagnoses . . . And I called my [practice] partner and my friend and I'm like, "Okay, I'm coming to the hospital tomorrow. I'm signing the forms. We'll induce over the weekend."

And then I changed my mind. You know, for me there was no—I don't really know, you know, it was kind of the inner voice that said, "Don't do it. Maybe you might get time with her or something." And we ultimately, we did, we got ten days with her.¹⁶⁷

¹⁶⁰ See Sherry F. Colb, *An Oklahoma Abortion Law Raises New and Different Rights Questions*, FINDLAW (July 21, 2010), <http://writ.news.findlaw.com/colb/20100721.html> (analyzing liability preclusion law). As with any medical intervention, physicians are generally expected to engage in counseling that should be non-directive and should err on the side of disclosure. See AM. MED. ASS'N COUNCIL ON ETHICAL & JUDICIAL AFFAIRS, OP. 8.082: WITHHOLDING INFORMATION FROM PATIENTS (2006), reprinted in CODE OF MEDICAL ETHICS: CURRENT OPINIONS WITH ANNOTATIONS 253–54 (2008); Sonia M. Suter, Note, *Whose Genes Are These Anyway?: Familial Conflicts Over Access to Genetic Information*, 91 MICH. L. REV. 1854, 1894 (1993).

¹⁶¹ See Mary Alice Carr, 'Oklahoma What Have You Done?', CNN.COM (Apr. 29, 2010, 9:15 AM), <http://www.cnn.com/2010/OPINION/04/28/carr.abortion.oklahoma/>.

¹⁶² See LORI FREEDMAN, WILLING AND UNABLE: DOCTORS' CONSTRAINTS IN ABORTION CARE 86–89 (2010) [hereinafter FREEDMAN, WILLING AND UNABLE].

¹⁶³ See *id.* at 90.

¹⁶⁴ See *id.*

¹⁶⁵ See *id.* at 77–78.

¹⁶⁶ See *id.* at 86–87.

¹⁶⁷ *Id.* at 87 (footnotes omitted).

At the time Dr. Anderson received the diagnosis, she still had more than four months remaining in her pregnancy.¹⁶⁸ She further explained her feelings about her decision and the time she had left as follows:

We just waited to see whatever would happen [and] I actually thought she was probably going to die in utero but she didn't . . . And then we ended up going into labor and having a regular labor up here [in the hospital] . . . They had said with one of the birth defects that she had, only about 3 percent make it to term, so we felt pretty lucky from that respect.¹⁶⁹

In telling her story, Dr. Anderson emphasized that “people can be pro-choice and still choose other options,”¹⁷⁰ as she did, but it’s only a *choice* if patients have the information to make that decision. As stated in *Canterbury v. Spence*, a landmark case on the law of informed consent, “the patient’s right of self-decision . . . can be effectively exercised only if the patient possesses enough information to enable an intelligent choice.”¹⁷¹ Without information, women and their families who would choose to keep the pregnancy as Dr. Anderson did will not have the opportunity to prepare emotionally for an infant’s serious illness or death and thus, as in her case, appreciate the time they might have; or to arrange appropriate care such as perinatal hospice; or to take financial steps to provide for a disabled child.¹⁷² Furthermore, certain fetal conditions require special care in utero. Early knowledge, decision-making, and intervention “is key to a positive outcome.”¹⁷³ In addition, in some cases testing can reveal information about fetal characteristics that could threaten the

¹⁶⁸ See FREEDMAN, WILLING AND UNABLE, *supra* note 162, at 87.

¹⁶⁹ *Id.* (second alteration in original) (internal quotation marks omitted).

¹⁷⁰ *Id.* at 88 (internal quotation marks omitted).

¹⁷¹ *Canterbury v. Spence*, 464 F.2d 772, 786 (D.C. Cir. 1972).

¹⁷² See Jaime Staples King, *Not This Child: Constitutional Questions in Regulating Noninvasive Prenatal Genetic Diagnosis and Selective Abortion*, 60 UCLA L. REV. 2, 65 (2012) [hereinafter King, *Not This Child*] (“[Early prenatal screening information] could help inform prospective parents’ decisionmaking regarding how best to care for their children both while they are in the womb and after they are born. . . . Advanced knowledge regarding a child’s medical or behavioral conditions can enable a parent to prepare for a child’s medical, nutritional, educational, and social needs as early as possible.”); see also Sujatha Jesudason & Julia Epstein, Editorial, *The Paradox of Disability in Abortion Debates: Bringing the Pro-Choice and Disability Rights Communities Together*, 84 CONTRACEPTION 541, 541–43 (2011) (arguing for a reproductive justice approach to protecting disability rights and reproductive rights which includes access to information). Jesudason and Epstein argue: “In the context of a prenatal diagnosis of disability, this means ensuring that women have the most accurate and comprehensive information possible, including realistic perspectives from individuals with the disability in question. A woman in this situation requires access to abortion services in a timely manner if she decides to terminate her pregnancy, and the supports necessary to sustain her family if she decides to carry the pregnancy to term.” *Id.* at 542.

¹⁷³ See King, *Not This Child*, *supra* note 172, at 65.

mother's health.¹⁷⁴ Once again, as with personhood legislation, this assertedly anti-abortion law affects far more than simply abortion decisions.

Liability-preclusion laws that provide an incentive for physicians to withhold material information and deviate from standards of care do little to address substantive concerns about disability discrimination. Anti-abortion proponents of these laws claim that they protect against disability discrimination in the womb.¹⁷⁵ Yet, laws like Oklahoma's obfuscate more substantive conversation about the need for government resources to support families with disabled children so that real choices can be made.¹⁷⁶ The economic harm caused by a failure to disclose is a consequence of the state's failure to provide adequate healthcare coverage for parents of disabled children during the child's minority and for disabled adults.¹⁷⁷ A disability rights approach would "highlight[] the social stigma attached to disability and the lack of environmental, social, political, and economic supports for families raising children with disabilities and for adults with disabilities."¹⁷⁸ Such an approach calls for more information, not less,¹⁷⁹ and for "[s]hift[ing] the overall strategy from fetal anomaly, rape, and incest as the messaging platform for abortion to ensuring that government provides the supportive and enabling conditions for families to make the best decisions for themselves."¹⁸⁰

¹⁷⁴ See Jaime S. King, *And Genetic Testing for All . . . The Coming Revolution in Non-Invasive Prenatal Genetic Testing*, 42 RUTGERS L.J. 599, 605–06 (2011) [hereinafter King, *Genetic Testing*].

¹⁷⁵ See Jesudason & Epstein, *supra* note 172, at 541–42; see also Samuel R. Bagenstos, *Disability, Life, Death, and Choice*, 29 HARV. J.L. & GENDER 425, 425–28 (2006) (discussing intersection of disability rights and abortion rights). However, increased prenatal screening may not necessarily correspond with higher abortion rates. See Rebouché & Rothenberg, *supra* note 39, at 1019.

¹⁷⁶ See Jesudason & Epstein, *supra* note 172, at 541–42 (noting that "[a]nti-choice advocates tend to idealize disability while opposing the entitlement programs and government funding of social services, such as state developmental disability programs . . . that would make raising a child with a disability more possible").

¹⁷⁷ See Stein, *supra* note 158, at 1166–68 (arguing that healthcare reform and nominal damages for denying a parent's right to choose are a better solution to medical malpractice in the context of negligence surrounding prenatal diagnoses of disabilities).

¹⁷⁸ Jesudason & Epstein, *supra* note 172, at 542.

¹⁷⁹ See *id.* at 542–43 (arguing that the role of government in helping families with prenatal disability diagnoses should be "to ensure the provision of comprehensive, unbiased, evidence-based information, not to force families to make certain, fixed, and limited decisions"); see also Bagenstos, *supra* note 175, at 441 (noting that some disability-rights advocates call for more accurate information rather than regulating abortion in the context of prenatal testing and selective abortion).

¹⁸⁰ Jesudason & Epstein, *supra* note 172, at 543; see also Rebouché & Rothenberg, *supra* note 39, at 987 (noting the need to take seriously the concern that pairing genetic testing and abortion "may suggest that disability is an appropriate rationale for termination of a pregnancy, further marginalizing individuals with certain genetic and physical conditions" and arguing for richer discussion of the intersection between prenatal genetic screening and abortion decision-making).

As early genetic screening becomes easier and more effective, we are likely to see more efforts towards information control as a method of regulating abortion.¹⁸¹ These information prohibitions targeted at abortion inevitably will affect all women and their families making decisions in the context of prenatal care, regardless of what may be their ultimate choice.¹⁸² As with personhood laws, the implications of information restrictions on a wide array of pregnant women's healthcare options may raise concerns for the public, if these side effects were made visible.

C. "Conscience" Legislation and Pregnancy-Related Care in Sectarian Hospitals

Both federal and state laws—known as "conscience clauses"—protect the right of institutions and individuals to refuse to provide abortion care and other medical care to which they conscientiously object.¹⁸³ Conscience legislation shields institutional and individual actors from liability for their refusal to provide care even if it contravenes accepted medical standards.¹⁸⁴ Although claiming to restrict only abortion provision, the refusal policies of many privately owned sectarian hospitals, ensured protection by conscience legislation, impede physicians' ability to provide appropriate care for pregnant women who are not actively seeking abortion care. In particular, pregnant women with emergent conditions such as a miscarriage or an ectopic pregnancy face risks to their health due to abortion restrictions.

Although other types of hospitals may also prohibit or limit reproductive health services, Catholic-owned hospitals represent the largest percentage of religiously affiliated hospitals, "operating 15.2% of the nation's hospital beds, and increasingly they are the only hospitals in certain regions within the United States."¹⁸⁵ This market share results in both Catholic and non-Catholic patients

¹⁸¹ See Rebouché & Rothenberg, *supra* note 39, at 987–1022 (analyzing the collision course between increasing access to prenatal genetic testing and decreasing access to abortion); King, *Genetic Testing*, *supra* note 174 (explaining advances in prenatal genetic screening and discussing implications for patient care and potential ethical issues); King, *Not This Child*, *supra* note 172 (arguing that women should possess the constitutional right to terminate a pregnancy for any reason, and states have a legitimate interest in only very limited circumstances for regulating access to information available through prenatal genetic testing).

¹⁸² For example, a number of states have already passed bans on abortion if the reason for seeking the abortion is because of the fetus' sex. If states choose to ban access to information on the sex of the fetus, such an information ban could also affect health issues since some genetic diseases are sex-linked. See King, *Not This Child*, *supra* note 172, at 26–29.

¹⁸³ See generally Elizabeth Sepper, *Taking Conscience Seriously*, 98 VA. L. REV. 1501, 1503 (2012) (describing and critiquing conscience legislation).

¹⁸⁴ See *id.*

¹⁸⁵ Freedman et al., *When There's a Heartbeat*, *supra* note 154, at 1774 (footnote omitted); see FREEDMAN, WILLING AND UNABLE, *supra* note 162, at 119–20. Freedman notes

depending on Catholic hospitals for their care. However, patients often remain unaware of how Catholic hospitals curtail their care options.¹⁸⁶ This section examines how Catholic hospital refusal policies based on “conscience” negatively impact pregnant women’s healthcare.

Catholic hospitals must follow the medical practice guidelines contained in the “Ethical and Religious Directives for Catholic Health Care Services” (Directives), a document drafted by the Committee on Doctrine of the National Conference of Catholic Bishops.¹⁸⁷ The Directives prohibit abortion, although some language in the Directives appears to allow a narrow exception for protecting the woman’s health.¹⁸⁸ In practice, Catholic hospital ethics committees—who ultimately make the decisions on the provision of abortion care—rely on a separate manual that interprets the Directives.¹⁸⁹ The manual provides that abortion is permitted if the physician intends to treat a “lethal pathology” in the pregnant woman when the treatment cannot be postponed until the fetus is viable.¹⁹⁰ The exception to protect the woman’s health outlined in the Directives and the manual are vague and contested, and hospital ethics committees’ effectuation of Catholic doctrine has led to delays in care resulting in psychological trauma, physical injury, and, in one recent case in Ireland, death.¹⁹¹

that, while there are other sectarian-owned hospitals, “Catholic hospitals have stood out, however, in both their numbers and policies.” *Id.* at 119. Catholic hospitals are the largest single group of not-for-profit hospitals in the country and, unlike other sectarian hospitals, operate in a sectarian manner by imposing limits on reproductive healthcare and end-of-life services. *See id.*; *see also* Sepper, *supra* note 183, at 1518–25 (describing widespread growth and impact of Catholic-owned hospitals).

¹⁸⁶ *See* Freedman et al., *When There’s a Heartbeat*, *supra* note 154, at 1774.

¹⁸⁷ U.S. CONFERENCE OF CATHOLIC BISHOPS, ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVICES 15 (2001) [hereinafter CATHOLIC BISHOPS, DIRECTIVES]; *see also* Freedman et al., *When There’s a Heartbeat*, *supra* note 154, at 1774–75. The Directives prohibit contraception, emergency contraception, infertility treatment, sterilization, and abortion. *See* CATHOLIC BISHOPS, DIRECTIVES, *supra*, at 23–28.

¹⁸⁸ *See* CATHOLIC BISHOPS, DIRECTIVES, *supra* note 187, at 23–28. Directive 47 provides: “Operations, treatments, and medications that have as their direct purpose the cure of a proportionately serious pathological condition of a pregnant woman are permitted when they cannot be safely postponed until the unborn child is viable, even if they will result in the death of the unborn child.” *Id.* at 27. In other words, abortion is permitted as “a secondary consequence of actions intended to preserve the health of the pregnant woman.” Freedman et al., *When There’s A Heartbeat*, *supra* note 154, at 1775; *see also* FREEDMAN, WILLING AND UNABLE, *supra* note 162, at 122–27 (discussing history of the Directives, vagueness on whether the exception only protects life or also health, and debates in implementing the Directives).

¹⁸⁹ *See* NAT’L CATHOLIC BIOETHICS CTR., CATHOLIC HEALTH CARE ETHICS: A MANUAL FOR ETHICS COMMITTEES (Peter J. Cataldo & Albert S. Moraczewski eds., 2001).

¹⁹⁰ *Id.* at 7A/3; *see also* Freedman et al., *When There’s a Heartbeat*, *supra* note 154, at 1775.

¹⁹¹ *See* Shawn Pogatchnik, *Savita Halappanavar Dead: Irish Woman Denied Abortion Dies from Blood Poisoning*, HUFFINGTON POST (Nov. 14, 2012, 4:20 PM), <http://www.huffingtonpost.com/2012/11/14/savita-halappanavar-death-irish-woman-denied->

Research indicates that pregnant women who are miscarrying, even long before viability, may face serious risks to their health due to anti-abortion policies at some hospitals. Physicians in one study reported that “Catholic doctrine, as interpreted by their hospital administrations, interfered with their medical judgment.”¹⁹² For example, “Catholic-owned hospital ethics committees [have] denied approval of uterine evacuation while fetal heart tones were still present, forcing physicians to delay care or transport miscarrying patients to non-Catholic-owned facilities.”¹⁹³ In a few cases, physicians even admitted to intentionally violating protocol “because they felt patient safety was compromised.”¹⁹⁴

The increased risks are primarily due to delays in care, in contravention to the accepted standards of care in miscarriage management.¹⁹⁵ For previable fetuses (less than approximately twenty-three weeks old), “little can be done to save the pregnancy if the membranes of the amniotic sac are ruptured.”¹⁹⁶ After that point, infection can threaten the health of the pregnant woman in a matter of hours. Therefore, physicians are trained to evacuate the contents of the uterus using the same procedures used in abortion care “when a woman show[s] up at the hospital who [is] less than twenty-three weeks pregnant, bleeding, and cramping, and [having] ruptured membranes”—because the pregnancy is over and the fetus is not viable.¹⁹⁷

abortion-dies_n_2128696.html (describing abortion law in Ireland and the story surrounding the death of a pregnant woman in Ireland who was denied an abortion during a miscarriage).

¹⁹² Freedman et al., *When There's a Heartbeat*, *supra* note 154, at 1774. For additional research on the effects of conscience legislation and Catholic hospital policy, see, for example, Stephane P. Fabus, *Religious Refusal: Endangering Pregnant Women and Professional Standards*, 13 MARQ. ELDER'S ADVISOR 219 (2012); Steph Sterling & Jessica L. Waters, *Beyond Religious Refusals: The Case for Protecting Health Care Workers' Provision of Abortion Care*, 34 HARV. J.L. & GENDER 463, 472–74 (2011); NAT'L WOMEN'S LAW CTR., *BELOW THE RADAR: HEALTH CARE PROVIDERS' RELIGIOUS REFUSALS CAN ENDANGER PREGNANT WOMEN'S LIVES AND HEALTH* 7–15 (2011), available at <http://www.nwlc.org/sites/default/files/pdfs/nwlcbelowtheradar2011.pdf>.

¹⁹³ Freedman et al., *When There's a Heartbeat*, *supra* note 154, at 1774.

¹⁹⁴ *Id.*

¹⁹⁵ See *id.* at 1775 (“According to the generally accepted standards of care in miscarriage management, abortion is medically indicated under certain circumstances in the presence of fetal heart tones. Such cases include first-trimester septic or inevitable miscarriage, previable premature rupture of membranes and chorioamnionitis, and situations in which continuation of the pregnancy significantly threatens the life or health of the woman.”).

¹⁹⁶ FREEDMAN, WILLING AND UNABLE, *supra* note 162, at 120.

¹⁹⁷ *Id.* The woman can then choose either to undergo a labor induction termination or a surgical termination; the surgical option is often seen as easier and more comfortable for a woman experiencing a miscarriage. See *id.* at 132 (“In the medical literature, ruptured membranes at fourteen weeks mean only one thing: spontaneous abortion is inevitable. Intravenous antibiotics might be able to delay infection for a while, but eventually the uterus would start prolonged cramping to expel the fetus and placental tissue. Such cramping with bleeding can last for an unpredictable amount of time, with continued risk of infection or

In contrast, the standards of medical care at some Catholic hospitals “are at variance with those generally recognized in other medical settings, particularly regarding care at the beginning and ending of life.”¹⁹⁸ In the context of miscarriage, the manual relied upon by Catholic hospital ethics committees declares: “The mere rupture of membranes, without infection, is not serious enough to sanction interventions that will lead to the death of the child.”¹⁹⁹ In other words, the authoritative source of medical guidance at Catholic hospitals approves of uterine evacuation “only after a woman becomes sick,” even in cases of inevitable miscarriage.²⁰⁰ In contrast, standard medical practice advises against delay during a miscarriage or if the pregnancy presents health risks, although ultimately the decision is left to the woman through a process of informed consent.²⁰¹ Yet, Catholic hospitals neither inform women of the full extent of the limits of their care, nor do they leave the decision of whether and when to terminate the pregnancy to the patient even in the context of a dire emergency.²⁰² Although execution of Catholic doctrines at hospitals throughout the United States varies at both the institutional and individual level,²⁰³ the anti-abortion policies of some hospitals have resulted in patients receiving delayed care and patients being transported to a nonsectarian hospital for treatment while miscarrying.

A few examples, told by physicians working in Catholic hospitals in the United States, illustrate the effects of sectarian hospitals' conscience-based refusal policies on pregnant patients seeking care for a miscarriage. In one case, Dr. Tiffany Howell, an obstetrician-gynecologist at a Catholic hospital in the Midwest, was forced to send her miscarrying patient by ambulance ninety miles to the nearest hospital that could perform the abortion, even though the patient was only fourteen weeks pregnant and the fetus had no chance of surviving. Dr. Howell explained:

hemorrhage, and that is why patients frequently undergo surgical uterine evacuation, which, especially early in the pregnancy, is quick and very safe.”).

¹⁹⁸ Freedman et al., *When There's a Heartbeat*, *supra* note 154, at 1775; *see also* Lori R. Freedman & Debra B. Stulberg, *Conflicts in Care for Obstetric Complications in Catholic Hospitals*, AM. J. ON BIOETHICS (forthcoming 2013), available at <http://www.tandfonline.com/doi/full/10.1080/21507716.2012.751464> (qualitative study finding that Catholic hospital policies detrimentally impacted physicians' ability to provide the standard of care in a variety of obstetric emergencies including cancer treatment for pregnant women, molar pregnancies, previable premature rupture of membranes, and miscarriages).

¹⁹⁹ NAT'L CATHOLIC BIOETHICS CTR., *supra* note 189, at 10A/2; *see also* Freedman et al., *When There's a Heartbeat*, *supra* note 154, at 1775.

²⁰⁰ Freedman et al., *When There's a Heartbeat*, *supra* note 154, at 1776.

²⁰¹ *See id.* at 1775 (describing informed consent process “which requires that the patient understand all appropriate medical options, as well as the relevant risks and benefits of each, before choosing and consenting to a course of management”).

²⁰² *See id.*

²⁰³ *Id.* at 1776.

Clearly, the membranes had ruptured and she was trying to deliver . . . There was a heart rate and [we called] the ethics committee and they [said], "Nope, can't do anything." So we had to send her to [the university hospital] . . . You know, these things don't happen that often, but from what I understand it, it's pretty clear. Even if mom is very sick, you know, potentially life-threatening, [you] can't do anything.²⁰⁴

Another physician explained that her Catholic-owned hospital rarely approved termination of pregnancy if a fetal heartbeat was present even for "people who are bleeding, they're all the way dilated, and they're only 17 weeks unless it looks like she's going to die if we don't do it."²⁰⁵

The effects of sectarian hospitals' anti-abortion policies spill over to area hospitals that perform the medical care that sectarian hospitals refuse. Dr. Carrie Becker, an obstetrician-gynecologist working in an academic medical center, described how a Catholic hospital in her area engaged in "patient dumping" by denying treatment and transporting patients in unstable conditions based on the hospital's anti-abortion doctrine.²⁰⁶ Dr. Becker received a request from a Catholic hospital to accept the transfer of a miscarrying patient who was already very sick from sepsis.²⁰⁷ Dr. Becker initially refused and advised that the Catholic hospital perform a uterine evacuation immediately to avoid risking the health of the woman any further.²⁰⁸ She described her conversation with the physician at the Catholic institution as follows:

Because the fetus was still alive, they wouldn't intervene. And she was hemorrhaging and they called me and wanted to transport her, and I said, "It sounds like she's unstable, and it sounds like you need to take care of her there." . . . And the physician [said], "This isn't something that we can take care of." And I [said], "Well, if I don't accept her, what are you going to do with her?" [He answered], "We'll put her on a floor [i.e., admit her to a bed in the hospital instead of keeping her in the emergency room]; we'll transfuse her as much as we can, and we'll just wait 'til the fetus dies."²⁰⁹

Dr. Becker felt that the intention to perform multiple blood transfusions to address the patient's blood loss and infection was bad medical practice.²¹⁰ She felt good medical practice would be to surgically evacuate the contents of the uterus, the source of the infection.²¹¹ Dr. Becker ultimately accepted the patient

²⁰⁴ FREEDMAN, WILLING AND UNABLE, *supra* note 162, at 128 (alterations in original).

²⁰⁵ Freedman et al., *When There's a Heartbeat*, *supra* note 154, at 1776 (internal quotation marks omitted).

²⁰⁶ FREEDMAN, WILLING AND UNABLE, *supra* note 162, at 129.

²⁰⁷ *See id.*

²⁰⁸ *See id.*

²⁰⁹ Freedman et al., *When There's a Heartbeat*, *supra* note 154, at 1776-77 (alterations in original).

²¹⁰ *See* FREEDMAN, WILLING AND UNABLE, *supra* note 162, at 129.

²¹¹ *See id.*

to spare her the unnecessary suffering and risks to her health.²¹² A few months later, a similar incident repeated from the same hospital and “demonstrated that this Catholic hospital was not doing terminations for even life-threatening medical indications.”²¹³

A number of physicians employed at Catholic hospitals have even confessed to subterfuge in the aim of protecting their patients' health.²¹⁴ In one case, Dr. Brian Smits, a perinatologist, reported resigning his position at a Catholic hospital rather than be subject to ethics committee decisions that harmed his patients.²¹⁵ Dr. Smits described the situation that instigated his resignation and his surreptitious violation of protocol in order to save his patient's life:

I'll never forget this; it was awful—I had one of my partners accept this patient at 19 weeks. The pregnancy was in the vagina. It was over. . . . I'm on call when she gets septic, and she's septic to the point that I'm . . . trying to keep her blood pressure up, and I have her on a cooling blanket because she's 106 degrees. And I needed to get everything out [of the uterus]. And so I put the ultrasound machine on and there was still a heartbeat, and [the ethics committee] wouldn't let me because there was still a heartbeat. This woman is dying before our eyes. I went in to examine her, and I was able to find the umbilical cord through the membranes and just snapped the umbilical cord and so that I could put the ultrasound—“Oh look. No heartbeat. Let's go.” She was so sick she was in the [intensive care unit] for about 10 days and very nearly died. . . . Her bleeding was so bad that the sclera, the white of her eyes, were red, filled with blood. . . . And I said, “I just can't do this. This is not worth it to me.” That's why I left.²¹⁶

Dr. Smits had assumed that the prohibition of abortion at his Catholic hospital would only affect his ability to offer abortions to patients with fetal anomalies or medical contraindications to pregnancy who would actively seek abortion care, which he could readily refer to abortion clinics outside the hospital. He had not expected “a disjuncture between what he considered to be the standard of care in miscarriage management and what was acceptable to his

²¹² See *id.*

²¹³ *Id.* In an opinion piece in the Journal of the American Medical Association, another physician described how a patient was transferred from a religiously affiliated to a nonsectarian hospital for abortion care in the context of ruptured membranes because the religious hospital would not allow the procedure until after the patient became septic. See Ramesh Raghavan, *A Question of Faith*, 297 JAMA 1412, 1412 (2007).

²¹⁴ See Freedman et al., *When There's a Heartbeat*, *supra* note 154, at 1776–77 (detailing several stories of physicians who circumvented ethics committee dictates in order to follow the standards of care they had learned in residency).

²¹⁵ See FREEDMAN, WILLING AND UNABLE, *supra* note 162, at 118–21; see also Freedman et al., *When There's a Heartbeat*, *supra* note 154, at 1777 (telling the same story of Dr. S).

²¹⁶ Freedman et al., *When There's a Heartbeat*, *supra* note 154, at 1777 (alterations in original).

hospital's ethics committee."²¹⁷ This disjuncture, which in an emergency threatened his patients' life, led to his resignation.²¹⁸ When asked what eventually happened to his patient, Dr. Smits stated: "She actually had pretty bad pulmonary disease and wound up being chronically oxygen-dependent, and as far as I know, [she] still is, years later. But, you know, she's really lucky to be alive."²¹⁹

Similar deviations from standards of medical care may also occur in the context of ectopic pregnancies. An ectopic pregnancy occurs when a fertilized egg implants outside the uterus, such as in the fallopian tube. An ectopic pregnancy has no chance of survival and threatens the life of the pregnant woman.²²⁰ The generally accepted standard of care dictates termination of the pregnancy, which can be done directly with medication that ends the pregnancy but preserves the fallopian tube. However, strict interpretation of Catholic doctrine would require the entire fallopian tube be removed so the physician only indirectly kills the fetus. Assuming two functioning fallopian tubes, the woman would lose fifty percent of her fertility.²²¹

In sum, research indicates that the refusal policies of at least some Catholic hospitals, which are sheltered by conscience legislation, "require physicians to act contrary to the current standard of care" and therefore compromises "the private patient-physician relationship, patient safety, and patient comfort."²²² These examples also belie the claim that a "health exception" to abortion restrictions will be sufficient to preserve women's health in the case of medically necessary pregnancy terminations. Medicine, particularly in the context of prenatal care, is not an exact science.²²³ The overlay of vague legal

²¹⁷ FREEDMAN, WILLING AND UNABLE, *supra* note 162, at 121.

²¹⁸ *See id.* at 120–21.

²¹⁹ *Id.* at 133 (alteration in original).

²²⁰ *See* NAT'L HEALTH LAW PROGRAM, HEALTH CARE REFUSALS: UNDERMINING QUALITY CARE FOR WOMEN 15, 40, 57 (2010), available at http://www.healthlaw.org/images/stories/Health_Care_Refusals_Undermining_Quality_Care_for_Women.pdf (discussing conscience clauses and restrictions on the use of emergency contraception and certain treatments for ectopic pregnancies).

²²¹ *See* FREEDMAN, WILLING AND UNABLE, *supra* note 162, at 170 n.5; *see also* Angel M. Foster et al., *Do Religious Restrictions Influence Ectopic Pregnancy Management? A National Qualitative Study*, 21 WOMEN'S HEALTH ISSUES 104, 106–07 (2011).

²²² Freedman et al., *When There's a Heartbeat*, *supra* note 154, at 1778; *see also* FREEDMAN, WILLING AND UNABLE, *supra* note 162, at 128–37 (further examining miscarriage management at Catholic-owned hospitals). The findings in these studies do not indicate how widespread the problem of delay and transport in miscarriage management is in Catholic hospitals; they do indicate that "Catholic medical practices reflect confusion and disagreement about how far to extend the Catholic Church's prohibition of abortion." *Id.* at 136.

²²³ *See* Maria Manriquez et al., Commentary, *Abortion Bills Out of Line with Accepted Standards of Prenatal Care*, ARIZ. CAPITOL TIMES, Apr. 6, 2012, at 7 ("The practice of medicine is as much an art as it is a science."). This opinion piece by three ob-gyns also discusses the side effects of bans on abortion at twenty weeks, stating that Arizona's twenty-week ban on abortion would affect all physicians practicing obstetrics even if they do not

rules on complex and time sensitive medical decision-making remains insufficient to protect women's health.

Given the market share of sectarian hospitals and their dominance in some regions, as well as the protection from liability granted by federal and state conscience legislation, refusal policies affect more than a population that believes in religious doctrine on women's healthcare. Although patients may be aware that they cannot obtain abortion care at certain sectarian hospitals, "few prenatal patients conceive of themselves as potential abortion patients and therefore they are not aware of the risks involved in being treated there," including the risks of physical and psychological trauma due to delayed care.²²⁴ Some of the side effects of protecting "conscience" refusals are directly analogous to the implications of personhood laws, such as interference with appropriate treatment of ectopic pregnancies, but these effects on women's healthcare remain largely unrecognized.

* * *

All of the above stories illustrate that abortion care cannot be isolated from women's healthcare as a whole. Any pregnant woman is a *potential* abortion patient. Similarly to personhood legislation, various existing limits on access to abortion care potentially place pregnant women's health and personal decision-making at risk.

V. *ROE V. WADE* AND ABORTION AS HEALTH CARE

Laws and policies that seem to only target abortion are much more politically acceptable due to abortion stigma, even though these restrictions have detrimental side effects on women's health analogous to personhood proposals.²²⁵ As discussed above in Part III, personhood laws appear to have failed because of the potential implications for women's health beyond the particular context of abortion. Even in Mississippi, where state officials with the support of the people have expressed the desire to be an abortion-free state, a majority of the public has demonstrated concern for ensuring continued access to medical care for pregnant women and for access to reproductive healthcare other than abortion.²²⁶ In this Part, I suggest that the battles over personhood legislation—and personhood's defeat—deserve further exploration. Debates over personhood proposals provide an example to learn from and an opportunity for public education. In particular, focusing attention on the side effects of

provide abortions since the twenty-week timeline "is simply not in line with routine prenatal care" and may even instigate abortions "because of the arbitrary time constraints." *Id.*

²²⁴ Freedman et al., *When There's a Heartbeat*, *supra* note 154, at 1778.

²²⁵ See Anuradha Kumar et al., *Conceptualising Abortion Stigma*, 11 *CULTURE, HEALTH & SEXUALITY* 625, 625–35 (2009) (analyzing abortion stigma); O'Donnell et al., *supra* note 133, at 135–63 (discussing stigma surrounding abortion for both patients and providers).

²²⁶ See *supra* Part III.B on failure of Mississippi initiative.

various anti-abortion laws—not just personhood laws—could help to unmask the links between abortion and women's healthcare. I also note that, as other scholars have argued, framing abortion as a healthcare issue offers a potentially useful strategy for preserving access to abortion care.

There are, of course, important differences between personhood laws and other types of abortion regulations. Nevertheless, the skirmishes over personhood proposals could be instructive for reproductive rights advocates. A key strategic opportunity may lie in erasing the artificial line between abortion care and other women's health issues. The public needs more education about how attacks on abortion affect women along a spectrum of healthcare needs. Debates about personhood initiatives have provided an opportunity to generate a public conversation that links abortion to the full range of interconnected women's healthcare issues. These debates could be used to explain to the public and to legislators that many types of abortion restrictions have unintended consequences which impede the provision of basic healthcare. Efforts in this direction could help bring back "a whole body, experience-based understanding of women's health that is predicate to gender equality and civic participation"—a view of women's health that Professor Lisa Ikemoto argues is being eroded under current health policies.²²⁷

The current segregation of abortion from women's healthcare brings us back to questions that have long been raised by *Roe v. Wade*. One oft-heard criticism of *Roe* is that it overemphasized abortion as a medical decision and the physician's role in that decision.²²⁸ For example, *Roe* claimed to "vindicate[] the right of the *physician* to administer medical treatment according to his professional judgment up to the points where important state interests provide compelling justifications for intervention."²²⁹ The Court described the abortion decision as "in all its aspects . . . inherently, and primarily, a *medical decision*, and basic responsibility for it must rest with the *physician*."²³⁰ Feminist scholars have amply and compellingly critiqued *Roe*'s medical model of abortion as undermining women's agency and reinforcing gender inequalities.²³¹

²²⁷ Lisa C. Ikemoto, *Abortion, Contraception and the ACA: The Realignment of Women's Health*, 55 HOW. L.J. 731, 732 (2011).

²²⁸ See, e.g., Susan Frelich Appleton, *Doctors, Patients and the Constitution: A Theoretical Analysis of the Physician's Role in "Private" Reproductive Decisions*, 63 WASH. U. L.Q. 183, 197–201 (1985); Reva Siegel, *Reasoning from the Body: A Historical Perspective on Abortion Regulation and Questions of Equal Protection*, 44 STAN. L. REV. 261, 273–79 (1992); see also Jack M. Balkin, *Roe v. Wade: An Engine of Controversy*, in WHAT *ROE V. WADE* SHOULD HAVE SAID: THE NATION'S TOP LEGAL EXPERTS REWRITE AMERICA'S MOST CONTROVERSIAL DECISION 3, 22 (Jack M. Balkin ed., 2005).

²²⁹ *Roe v. Wade*, 410 U.S. 113, 165–66 (1973) (emphasis added).

²³⁰ *Id.* at 166 (emphasis added).

²³¹ B. Jessie Hill, *Reproductive Rights as Health Care Rights*, 18 COLUM. J. GENDER & L. 501, 510–15 (2009) [hereinafter Hill, *Reproductive Rights*] (summarizing feminist critiques of *Roe*'s medical model of abortion and critiques of medicalization of reproductive healthcare more broadly).

Although *Roe* was rightly criticized as over-medicalizing the abortion decision and empowering doctors rather than women, we have now shifted to the opposite extreme. Today, abortion is hardly considered medical care at all.²³² The Supreme Court's most recent abortion decision, *Gonzales v. Carhart*, bears a striking contrast to *Roe* in this regard.²³³ In *Carhart*, the Supreme Court described the abortion decision as purely political in nature and one that is made as a matter of "convenience."²³⁴ The Court ignored extensive medical evidence on the health reasons for employing the banned procedure, leaving it to legislatures and courts, rather than physicians and their patients, to determine how best to protect women's health.²³⁵

Other laws and policies also illustrate the isolation of abortion from the rest of women's healthcare, which has contributed to its stigmatization.²³⁶ For example, excluding abortion from healthcare coverage, as the Affordable Care Act (ACA) does, "underscores the perception that abortion services, unlike [prenatal] testing services, have *no relation* to protecting women's physical or mental health."²³⁷ The ACA has also spawned new state laws that prevent private insurers from offering abortion coverage on state exchanges.²³⁸ The Hyde Amendment similarly prohibits federal Medicaid funding for abortion care for poor women, except where the pregnancy resulted from rape, incest, or will endanger the woman's life.²³⁹ Abortion is the only medical procedure exempted from federal Medicaid funding.²⁴⁰ In addition, a series of other

²³² See Rebouché & Rothenberg, *supra* note 39, at 1006 (noting that the ACA typifies this view, covering prenatal screening and testing as essential healthcare but excluding and segregating abortion coverage).

²³³ See *Gonzales v. Carhart*, 550 U.S. 124, 164–68 (2007).

²³⁴ See *id.* at 186–87 (Ginsburg, J., dissenting).

²³⁵ See *id.* at 164–68; see also B. Jessie Hill, *What Is the Meaning of Health? Constitutional Implications of Defining "Medical Necessity" and "Essential Health Benefits" Under the Affordable Care Act*, 38 AM. J.L. & MED. 445, 454–55 (2012) (analyzing *Gonzales v. Carhart*'s reasoning on health exception).

²³⁶ See Carole Joffe & Willie J. Parker, Editorial, *Race, Reproductive Politics and Reproductive Health Care in the Contemporary United States*, 86 CONTRACEPTION 1, 2 (2012) (noting that isolation of abortion from healthcare contributes to its stigmatization and to conspiracy theories of racial eugenics).

²³⁷ Rebouché & Rothenberg, *supra* note 39, at 1007; see also Ikemoto, *supra* note 227, at 755 ("As a matter of federal health law and policy, abortion and the women who choose it barely exist.").

²³⁸ See Ikemoto, *supra* note 227, at 761.

²³⁹ The Hyde Amendment was first passed in 1976 as the Departments of Labor and Health, Education, and Welfare Appropriations Act, Pub. L. No. 94-439, § 209, 90 Stat. 1434 (1976), and it has been reauthorized by each Congress since then, although the exact scope and wording of the exceptions have shifted over time. For a recent version of the Hyde Amendment, see Consolidated Appropriations Act, 2010, Pub. L. No. 111-117, §§ 507–08, 123 Stat. 3280 (2009).

²⁴⁰ See NAT'L NETWORK OF ABORTION FUNDS, *What Is the Hyde Amendment?*, FUNDABORTIONNOW.ORG, <http://www.fundabortionnow.org/learn/hyde> (last visited Feb. 11, 2013) (explaining the Hyde Amendment's effect on Medicaid coverage for abortion).

federal laws allow healthcare providers and entities to refuse to perform or assist with abortion care, to provide or arrange training for such care, or to refer patients to abortion care.²⁴¹ In sum, “[a]s a matter of national health policy, abortion services have been severed and isolated from women’s health.”²⁴²

As illustrated by the failure of personhood proposals, reproductive rights advocates should consider highlighting the medical aspects of abortion to awaken the public to the ripple effects of anti-abortion regulations on women’s health. Surfacing the spillover effects of abortion restrictions could help the public to better see and understand the links between abortion and women’s healthcare. In the personhood context, coalitions that included a wider swath of the medical community seem to have successfully connected abortion care with other healthcare through public education. In other words, by emphasizing the relationship between abortion care and pregnancy care, contraception, fertility, and women’s health in general, opponents of personhood defeated this type of abortion ban with support from those who otherwise favor restricting or banning abortion. Perhaps this strategy could apply more broadly.²⁴³ Further public education on the “side effects”—the arguably unintended consequences—of various types of abortion restrictions may cause people to perceive a similar connection between abortion care and women’s health in the context of other abortion laws, leading to less sympathy for at least more extreme restrictions on access to abortion care.

Realigning abortion with healthcare and repositioning the law to recognize access to abortion care as a critical part of the continuum of women’s medical needs is essential to protecting women’s health.²⁴⁴ As Professor Jessie Hill has argued, “describing abortion as an aspect of health care may get members of the public to recognize the intrusive and harmful nature of anti-choice legislation, much of which . . . directly regulates the intimate relationship between

²⁴¹ See Ikemoto, *supra* note 227, at 759 (describing a variety of federal laws and policies that allow for refusals by institutions and providers, including the Church Amendments and the Weldon Amendment).

²⁴² *Id.* at 762. Professor Ikemoto notes that this narrowing of the scope of women’s health will have devastating consequences because federal health policy omits a procedure that an estimated three in ten American women will have by age forty-five. *Id.* at 763.

²⁴³ It would be useful to have further empirical research analyzing more thoroughly why personhood proposals failed in various jurisdictions and what might be the relevant distinctions between the public’s perceptions of personhood laws versus other abortion restrictions. For example, it may be helpful to know what kinds of side effects, for example, restrictions on IVF versus restrictions on healthcare for pregnant women, swayed opinion more; which advocacy groups, for example, coalition medical groups versus groups focused on women’s health, swayed opinion more; and what kinds of public education by opponents of personhood served best to persuade the public.

²⁴⁴ See Rebouché & Rothenberg, *supra* note 39, at 1022 (“It is critical to women’s health and well-being that abortion is part of a continuum of health care.”).

physician and patient.”²⁴⁵ The public appears to be sympathetic to criticism of government intrusion into healthcare decision-making, even where abortion may be an aspect of those decisions.²⁴⁶ To be clear, I am not arguing that abortion is *only* a medical issue, as *Roe* incorrectly claimed. Rather, seeing and understanding abortion as healthcare offers one important and useful approach for bolstering access to safe and legal abortion, along with emphasis on the importance of abortion rights for preserving women’s equality and liberty.²⁴⁷ Recasting abortion as a normal aspect of women’s medical care could be accomplished without returning to *Roe*’s medical model of abortion that portrayed women as passive receivers of care determined by their physicians.²⁴⁸ For example, informed consent law, which emphasizes the patient’s right to bodily integrity and self-determination, provides a medical model that respects patient autonomy.²⁴⁹

Of course, there are difficulties in discussing the medical realities of abortion and related healthcare issues. Professor Tracy Weitz has noted that even abortion rights advocates find it difficult “to talk about abortion as a medical service rather than in legal terms.”²⁵⁰ Describing the medical realities of abortion is highly unpleasant, as is describing the medical realities of miscarriage or other pregnancy related health issues, since these all involve “private and intimate parts of the female anatomy and blood, mucus and other

²⁴⁵ B. Jessie Hill, *Abortion as Health Care*, 10 AM. J. BIOETHICS 48, 49 (2010) [hereinafter Hill, *Abortion*]; see also Hill, *Reproductive Rights*, *supra* note 231, at 502 (arguing for embracing a strategy that emphasizes abortion as a form of healthcare).

²⁴⁶ For example, the defeat of Measure 26 in Mississippi appeared due at least in part to “concerns that the measure would empower the government to intrude in intimate medical decisions” related to pregnancy care and reproductive healthcare. Denise Grady, *Medical Nuances Drove ‘No’ Vote in Mississippi*, N.Y. TIMES, Nov. 15, 2011, at D1.

²⁴⁷ See Hill, *Reproductive Rights*, *supra* note 231, at 504 (arguing that framing abortion as part of a negative right to medical care is one useful way to frame abortion rights and “should be deployed alongside existing arguments about privacy, autonomy, equality, and dignity”); Ikemoto, *supra* note 227, at 763 (arguing for importance of linking women’s health with rights to self-determination and equality).

²⁴⁸ Yvonne Lindgren, *The Rhetoric of Choice: Restoring Healthcare to the Abortion Right*, HASTINGS L.J. (forthcoming 2013), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2124844, at p.46 (arguing for restoring a view of abortion as a healthcare right while also rejecting the notion of women as passive recipients of care).

²⁴⁹ See Manian, *supra* note 40, at 235–42 (describing the common law origins and core principles of the law of informed consent).

²⁵⁰ Weitz, *supra* note 148, at 27.

bodily secretions.”²⁵¹ Yet, as other scholars have argued, focusing on abortion as an aspect of healthcare is potentially a powerful strategy.²⁵²

VI. CONCLUSION: THE PERSONHOOD OF PREGNANT WOMEN

Abortion is both a social *and* a medical issue.²⁵³ To establish fetal personhood by law would not only deprive pregnant women of their legal personhood, but also would place women’s health in jeopardy whether or not they are actively seeking abortion care.²⁵⁴ The public has been supportive of legislation that appears to target only abortion, even though many of these laws impinge upon women’s healthcare similarly to personhood legislation. Although there are important differences between personhood proposals and other types of abortion restrictions, personhood laws offer insight into larger problems with abortion restrictions. As a practical matter, abortion cannot be isolated from women’s health more broadly. We can see this by analyzing the “side effects” of anti-abortion legislation such as personhood laws and existing restrictions on abortion care. Reproductive rights advocates should aim to erase the artificial boundary between abortion care and women’s healthcare. Public education, unwittingly spurred on by personhood proposals, could help to increase awareness that laws attacking abortion inevitably have wider consequences for women’s health.

²⁵¹ *Id.* (“Abortion is indeed a medical procedure For years, prochoice advocates could avoid any discussion of the unpleasant side of abortion techniques, pivoting instead to the horrific and graphic stories of illegal abortion. Consequently, when confronted with the ‘partial birth abortion’ fight abortion rights activists were unprepared for talking about the medical realities of abortion.”).

²⁵² See, e.g., Hill, *Abortion*, *supra* note 245, at 49; Lindgren, *supra* note 248 (arguing that uncoupling abortion from healthcare leaves access to abortion vulnerable to erosion by courts and legislatures).

²⁵³ See Weitz, *supra* note 148, at 28 (“Abortions are socially complicated and medically unpleasant to describe . . . but advocates for abortion rights are best served by acknowledging rather than trying to ignore this dimension.”).

²⁵⁴ See Dawn E. Johnsen, *The Creation of Fetal Rights: Conflicts with Women’s Constitutional Rights to Liberty, Privacy, and Equal Protection*, 95 YALE L.J. 599, 620 (1986) (“To deprive women of their right to control their actions during pregnancy is to deprive women of their legal personhood.”).